INSPIRE HEALTH

Medical Records Release Form

By signing this form, I authorize you to release a confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below:

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ❏ Complete Records
- ❏ Care Plan
- ❏ Pathology Reports
- ❏ Hospital Reports
- ❏ History & Physical
- ❏ Lab Reports
- ❏ Treatment Record
- ❏ Medication Record
- ❏ Progress Notes
- ❏ Radiology Reports
- ❏ Operative Reports
- ❏ Other (please specify)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

To:	From:
Inspire Health 5575 Warren Parkway #115 Frisco, TX 75034 Phone:469-200-6100 **Fax: 469-200-6101**	Physician: _____ Practice: _____ Address: _____ _____ Phone: _____ Fax: _____

The purpose/reason for this release of information is as follows: _____

_____

_____ _____

Patient Name | Signature of Patient or Personal Representative

_____ _____

Patient Date of Birth or Social Security Number | Printed Name of Patient or Personal Representative

_____

Date