SAGE MEDICINE

MEDICAL RECORDS RELEASE FORM

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Patient name: _____ DOB: _____

Patient address: _____

City/State/Zip: _____ Phone:_____

By signing this form, I authorize you to release 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 entity listed below.

I hereby authorize the release of information:

From:

_____
_____
_____
_____
_____
_____

TO:

Carmen Cawley, MD
Sage Medicine, PA
4315 Moonlight Way
Suite 102
San Antonio, TX 78230
Phone: (210) 510-2141
Fax: (210) 510-2135

Information to be released:

☐ All items indicated below:

☐ Progress Notes / Consultation Notes (1 year only)
☐ Medical Summary
☐ Pathology Reports
☐ Immunization Records
☐ Endoscopy Reports
☐ Lab Reports
☐ Radiology Reports
☐ Cardiac Reports
☐ Pulmonary Reports
☐ Operative Reports
☐ ER Records: Date:_____
☐ Hospital Records: Date:_____
☐ Other: _____

Please respond to this request within a reasonable time to avoid delays in patient care.

_____ _____
Patient, guardian, or legal representative (signature) **Date:**

Office use only:
Date faxed: _____ Date mailed: _____ Initials: _____