Bent Tree Family Physicians

Board Certified Family Physicians

Guy Culpepper, M.D.
Bryan J. Ferguson, M.D.
Alma D. Garza, M.D.
Amy M. Latta, M.D.
Richard B. Bridwell, M.D.
Collin R. Jones, M.D.
Tariq H. Khan, M.D.

Authorization for Medical Records Release

Patient Information:

Name (Last, First Middle) _____ Social Security # _____ D.O.B. _____

Home Address _____ Home Phone # _____

City, State, Zip Code _____ Work Phone # _____

Information Released From:

Name of Clinic/Physician _____

Street Address _____

City, State, Zip Code _____

Phone Number (area code) _____

Fax Number (area code) _____

Information Released To:

Name of Clinic/Physician _____

Street Address _____

City, State, Zip Code _____

Phone Number (area code) _____

Fax Number (area code) _____

TYPE/ EXTENT OF RECORDS TO BE DISCLOSED: (CHECK ONE)

(Please note that a fee may be required with this service)

____Records pertaining to: _____
(Specific dates or conditions)

____Entire patient records

Purpose or need for disclosure: (check one)

_____Personal
_____Consult / Specialist
_____Selected a new physician
_____Moving out of town
_____Change of Insurance
_____Insurance Application

All records pertaining to mental health, chemical dependency, and/ or AIDS/ AIDS related illness will be released unless otherwise indicated in writing.

_____

_____

I hereby authorize release of my medical records. I understand that this release is valid for 90 days from date of signature, and that I may revoke this authorization in writing. I agree that any release made prior to this revocation will be made in compliance with this authorization. This information may be subject to re-disclosure by the recipient and is no longer protected by the privacy rule.

_____ _____
Patient Signature/ Legal Guardian Date