MEDICAL RECORDS RELEASE FORM

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 person(s) or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **INITIAL:**_____ **DATE:** _____

I hereby authorize:
Physician: _____
Address: _____
City, State, Zip: _____

To release to: **ROBERT T. GUNBY JR., M.D.**
PAUL B. PAYNE, M. D.
CHRISTINA P. LITTRELL, M. D.
LYNDSEY M. HARPER, M. D.
4224 Swiss Avenue
Dallas, Texas 75204
214-821-9938 FAX: 214-823-2426

Limitations on the information you may release subject to this release form are as follows: _____

_____

_____

The reasons or purposes for this release of information are as follows: _____

_____

_____

Patient Signature (or parent, guardian or legal representative)

_____ DATE: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

PATIENT NAME: _____
PATIENT DATE OF BIRTH: _____
PATIENT SOCIAL SECURITY: _____