



Stanley H. Kim, MD; Jeff T. Miley, MD; Anant I. Patel, MD
12180 North Mopac; Suite B; Austin, TX 78758

Medical Record 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.

NAME: _____ DOB: _____

Limitations on the information you may release subject to this Release Form are as follows:

HIV/AIDS: I consent to the release of any positive or negative test result of 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:** _____

Release my protected information to the following person(s)/entity:

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

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.