Your Choice®
Primary Care

Authorization for Release of Medical Records

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care be released as set forth on this form:

Name and address of health provider or entity to release this information:	
Name and address of health provider or entity to whom this information will be sent: ***Your Choice Primary Care, 3420 K Ave. Ste 305, Plano, TX 75074 Phone: 1 844) 968-2464, Fax: 469) 304-9399***	
Information to be released: Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, and records sent to you by other health care providers. Include: (*Indicate by Initialing*) **_____ Alcohol/Drug Treatment** **_____ Mental Health Information** **_____ HIV-Related Information**	
Reason for release of information: Continuity of Care	Date or event on which this authorization will expire: (Unless specified, this authorization will expire 180 days after the date it is signed.)
If not the patient, name of person signing form:	Relationship to Patient:

All items on this form have been completed and my questions about this form have been answered.

_____ Date: _____

Signature of patient or representative authorized by law.