Lake Country
Family Medicine

RELEASE OF RECORD FORM

I consent and authorize Lake Country Family Medicine and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records. Including but not limited to, information concerning communicable diseases, such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory results, medical history, treatment progress, and/or any other such information to be transmitted via U.S. mail, facsimile, or other electronic medium. This consent to release medical information is subject to revocation in writing at any time, except to the extent that action has been taken.

RELEASE FROM:

Clinic/Hospital: _____

Phone: _____ **Fax:** _____

Address: _____ **City/St:** _____ **Zip:** _____

☐ All medical records including labs, radiology, and doctor's notes

☐ Doctor's Notes ☐ Lab only ☐ Others: _____

RELEASE TO:

Provider: Dr. Yung Chen D.O. Dr. Jill Gramer, D.O.

Address: 8465 Boat Club Road, Suite 115 Fort Worth, TX 76179

Phone: (817) 260-0535 **Fax:** (817) 984-1448

Patient Name: _____ **DOB:** _____

Patient/Parent Signature: _____ **Date:** _____