



11105 Landmark Ct.
Denton, TX 76207
Phone: (214) 518-5016
Fax: (800) 548-9128

Authorization and Request for Release of Medical Information

Patient Name: _____
Last 4 of SSN: _____
Date of Birth: _____

RELEASE RECORDS __ TO __ FROM
Argyle Health Services, PLLC DBA Adult Health Services
11105 Landmark Ct Denton, TX 76207
Phone: (214)518-5016

RELEASE RECORDS __ TO __ FROM

Request is made and permission is granted to release the following:

- | | |
|--|--|
| _____ Admission History and Physical | _____ Lab Results |
| _____ Alcohol or Substance Abuse Records | _____ Mammogram Results |
| _____ Discharge Summary | _____ Mental Health Records / Notes |
| _____ EKG / Echo / Stress Results | _____ Office Visit Notes |
| _____ Entire Health Record | _____ Operative / Procedure Reports |
| _____ Eye Exam Results | _____ Pathology / Biopsy Reports |
| _____ Imaging Results | _____ Treatment of AIDS or HIV records |

Dates of service to include date from _____ **to** _____

The purpose of this request is for the following reason(s)

- _____ at the request of the individual
- _____ for continuity of medical management
- _____ transfer of care to another provider or leaving the area.

This authorization shall expire on the earlier of 6 months from the date signed, or on (Date) _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Argyle Health Services, PLLC dba Adult Health Services Attention Medical Release Correspondent, at the above address.

I hereby authorize AHS or Adult Health Services to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

Patient Name: _____
Patient Signature: _____ **Date:** _____
Phone: _____

Legal Representative: _____ **Date:** _____
Relationship: _____

Witnessed by: _____ **Date:** _____

Tracy Cook, RN, ANP-C