409 NORTH SIXTH STREET • LONGVIEW, TEXAS 75601
TELEPHONE 903-758-2746 • FAX 903-758-7127

MEDICAL RECORDS RELEASE FORM

I, ____, (DOB:_________________) understand that the information contained in my medical record is confidential. However, I specifically give my consent for Longview Orthopaedic Clinic Association to release medical information to other doctors for further treatment in my care, hospitals, and/or insurance companies and other health care agencies.

This consent may be revoked at any time up to the time that action is taken. It is further understood that the information released is for professional purposes only and should not be provided in whole or part to any other agency, organization, or person other than stated above.

I understand that treatment services are not contingent upon my signing or not signing this consent form. I freely and voluntarily give my consent for the release of information from my medical record.

________________________________	________________________________
SIGNATURE OF PATIENT (OR PARENT, IF A MINOR)	Other names patient may be listed under (i.e., maiden or other married names)

____

DATE

#12804 3/2011