Patient Name: _____

Texoma Primary Care Associates

5810 Collin McKinney Pkwy, Ste 202 McKinney TX 75070
Ph 972-919-0721 Fax # 972-919-0725

Release of Medical Records

Patient Name: _____D.O.B._____
Telephone number:_____SSN/Medical Record :_____

Release Information from
Specify Provider/Organization Name and Facility Address

Organization Name: _____
Address: _____

1. **Information authorized for disclosure**, if included in my records,
   - Progress notes including history and physical
   - Laboratory results, x-ray imaging reports (Mammogram, CT, MRI, etc.)
   - Entire Medical record
   - Treatment From (date) _____To (date)_____

2. I understand that the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services and treatment or testing for alcohol or drug abuse.

3. I authorize the disclosure of the listed information to send to the following individual or organization:

   Name: **Texoma Primary Care Associates**
   Dr Umesh Kumar MD
   Address 5810 Collin McKinney Pkwy, Ste 202 McKinney TX 75070
   Phone: **972-919-0721** Fax: **972-919-0725**
   For the purpose of: _____

4. I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to the office. I understand that the cancellation will not apply to the information that has already been released under this organization. I understand that this cancellation will not apply to my insurance company when law gives my insurer the right to consent a claim under my policy number.

5. Unless I cancel it sooner, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date appearing at the bottom.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain medical treatment. However, information will not be released to the above indicated individual or organization without my signature.

Signature of patient or legal representative: _____; **Date:** _____