PARIS LAKES HEALTH GROUP

Records Release Request

To: _____ Ph:_____

_____ Fax:_____

_____

I hereby authorize the release of copies of my medical records and request that they be sent to:

Paris Lakes Health Group
Alois Pauls, MD
Carolyn Robinson-Cowley FNP-BC
2675 41st ST SE, Suite 102
Paris, Texas 75462

Phone: (903)-785-3000
Fax: (903)-785-3005
Do not fax over 10 pages, please mail instead*

☐ The last two (2) years records

The purpose of this information:
_____

Name: _____

Date of birth: _____ S.S.# _____

Address: _____

_____

Home phone: _____ Work: _____

I further understand that I retain the right to revoke this authorization at any time. All revocation must be in writing and submitted to the Privacy Officer.

This authorization will expire in 90 days from the date signed.

THANK YOU FOR YOUR ATTENTION TO THIS MATTER

_____ _____
Patient Signature Date

_____ _____
Witness Date

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infections with any other causative agent with the rest of my medical records. Initial_____