

**Medical Record Release Consent**

I, \_\_\_\_\_ hereby request and authorize my medical records be released to:

**ACHYJOINT**  
**320 Kingwood Executive Dr. STE D**  
**Kingwood, Texas 77339**  
**Phone: 281-406-0484**  
**Fax: 832-220-3322**

FROM: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To release the complete medical records in your possession concerning my illness and/or treatment from \_\_\_\_\_ to \_\_\_\_\_

This authorization applies to all of the reports checked:

- \_\_\_\_ My complete health record
- \_\_\_\_ Laboratory test reports
- \_\_\_\_ X-Ray reports

**Purpose of Disclosure**

- \_\_\_\_ Attorney/Legal
- \_\_\_\_ Insurance Claim Processing
- \_\_\_\_ Personal use
- \_\_\_\_ Continued Patient Care
- \_\_\_\_ Referral
- \_\_\_\_ Other \_\_\_\_\_

**PLEASE FAX RECORDS TO OUR SECURE FAX: 832-220-3322**

I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in the reliance on this account.

Signed \_\_\_\_\_ Date of Birth \_\_\_\_\_

Witness \_\_\_\_\_ Date Signed \_\_\_\_\_