Texas Telemedicine Doctor

P: 512-588-2507
F: 506-700-6425
www.texastelemedicinedoctor.com

Medical Release Form

Date:
Name:
Date of birth:
Telephone #:
Address:

I, the above-named individual, do hereby authorize

Doctor/Facility/Other:
Fax:
Phone:
Address:

to disclose and release personal medical information to:

Dr. Todd Crump at Texas Telemedicine Doctor
Fax: (506) 700-6425
Phone: (512) 588-2507

Information to be released (check all that apply):

Entire medical record	Discharge summaries
Radiology reports	Progress notes
Consultations	Lab reports
Other	

I understand that these records may include personal information relating to sexually transmitted diseases (including HIV), mental health conditions, and drug and alcohol abuse. I am requesting the release of this information because I have sought care from Dr. Crump, and I would like him to have my previous records. I understand that the release of this information is voluntary, and I am not obligated to sign this release for any reason. I also understand that this release will expire in 180 days from the above date, unless I otherwise specify here - (Date of expiration). I may also revoke this release at any time by submitting a written request to Dr. Crump.

_____

Signature of patient or patient's representative Date

Printed name of patient or representative