MEDICAL RECORDS RELEASE

_____ I hereby request to have my medical information, including but not limited to office progress notes, reports from labs and other studies, summaries of treatment, consultation reports and verbal/telephone/electronic communication released to:

Evershine Med, PLLC
1701 Forest Ridge Dr
Bedford, TX 76022
Phone: 817-545-7700/Fax: 817-545-2298

_____ I hereby authorize the providers at Evershine Med, PLLC, to release my medical information, including but not limited to office progress notes, reports from labs and other studies, summaries of treatment, consultation reports and verbal/telephone/electronic communication to the following person or organization:

_____

_____

_____

I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue until termination of treatment unless otherwise specified. I understand that I may revoke this release of information at any time. I understand, reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

To the extent that my medical records contain information regarding alcohol or drug treatment that is protected by Federal Regulations 42CFR, Part 2, I authorize disclosure of such information.

Signature: _____

Printed Name: _____

Relation to Patient: _____

Date Signed: _____ Date of Birth: _____

Address: _____

_____