Physical Address: 1109 Church Street, Bastrop, TX 78602
Phone: (512) 321-3311 Fax: (512) 321-2611

Mailing Address: **PO Box 664, Bastrop, TX 78602**
website: *www.drsammylerma.com*

Request for Release of Medical Information to Sammy Lerma III MD PA

Patient Full Name (PRINT)____
Address:____
Telephone Number: ______________________________Date of Birth____________________

I hereby request that records from the below doctor/organization be faxed to Sammy Lerma III MD PA:
Name of Doctor/Organization: ____
MAILING ADDRESS: ____
Fax number: ____________________ Phone number: ____________________

PLEASE CHECK SPECIFIC INFORMATION REQUESTED:

Dates of treatment: ☐ All dates OR ☐ Specific dates: from ______________ to ______________

☐ All Medical Records **OR**	☐ Abstract of record (Office Notes, Procedures, & Test Results Only)

OR CHECK SPECIFIC RECORDS

☐ Discharge Summary ☐ History & Physical ☐ Hospital/ER visit ☐ Images ☐ Immunizations	☐ Lab reports ☐ Medication List ☐ Surgical History ☐ Occupational Health Rec ☐ Pathology reports	☐ Physical Therapy Notes ☐ Physician Office Visits ☐ Progress Notes ☐ Radiology (x-ray) reports ☐ Other: (specify) ______________

Description of the purpose of the use and/or disclosure

☐ Continuing Care ☐ Consultation/Referral ☐ Insurance	☐ Primary Care Physician ☐ Legal purposes ☐ Second Opinion	☐ Social Security/Disability ☐ Other: (specify) ______________

FAX TO:
Sammy Lerma III MD PA
Medical Records
512-321-2611

CONDITIONS and NOTIFICATIONS:
I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.
I understand that this authorization is voluntary and I may refuse to sign this authorization; I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form.
State law allows a patient to obtain a copy of his/her records or ask that a copy be sent to other parties. I hereby authorize the use or disclosure of the personal health information described above. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to disclosure.
I understand that I may revoke this authorization at any time by notifying Sammy Lerma III MD PA. I understand that if I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

EXPIRATION: This authorization will expire 180 (6 months) from the date of my signature, or specified as follows:
____

Signature of Patient or Guardian ______________________________ Date ____________________
Relationship to Patient (Self, Parent, Care Provider, etc.) ______________________________