Comfort Minds & Above Behavioral Health
9500 Ray White Rd Ste 200
Fort Worth, Texas, US - 76244

Request for Records

Comfort Minds & Above Behavioral Health

9500 Ray White Road, Suite 200

Fort Worth, Texas 76244

Ph- 817-745-4632

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be dated and signed by the patient or by a legally authorized person.

I authorize Comfort Minds & Above Behavioral Health to: * ☐ Obtain ☐ Release

Copies of my medical records from:

Practitioner Name: * _____

Practice Name: * _____

Phone Number: * _____

Fax Number: * _____

The information will be used on my behalf for review of past medical history and for the following purpose:

(if any indicated) _____

I specifically authorize the release of the following medical records, if such records exist:

☐ All Medical Records ☐ Transcribed Hospital Records ☐ Most Recent Five Year History
☐ Emergency and Urgent Care Records ☐ Diagnostic Imaging Reports ☐ Laboratory Reports
☐ Pathology Reports ☐ Clinician Office Chart Notes

The following items to be included in other documents.

☐ HIV/AIDS Related Records ☐ Mental Health Information ☐ Genetic Testing Information
☐ Drug/Alcohol Diagnosis, Treatment, or Referral Information

Describe (Federal regulations require a description of how much and what kind of information is to be disclosed).

This authorization is for all records unless otherwise indicated below.

This authorization is limited to records regarding the following treatment: _____

This authorization is limited to records from the following time period: _____

This authorization is limited to a worker's compensation claim for injuries on(Date): _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

Patient's First and Last Name * _____

Date of Birth * _____

Date: * _____

Patient Signature or Parent's / Guardian's Signature * _____