

ELIAS I. FANOUS JR., M.D., P.A.

921 Shiloh Road, Suite C-300 | Tyler, TX 75703

Phone: 903-526-3030 | Fax: 903-526-3036

MEDICAL RECORDS REQUEST & AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This form is for medical-records requests only. Do not use it for medical questions or urgent clinical concerns.

PATIENT INFORMATION

Patient Name (print): _____ DOB: _____

Patient Address: _____ City / State / ZIP: _____

AUTHORIZATION AND RECIPIENT

I authorize Elias I. Fanous Jr., M.D., P.A. to disclose my health information as directed below.

Release records to (name): _____ Phone: _____

Address: _____ Fax: _____

RECORDS REQUESTED

☐ Copy of my pertinent medical records, as maintained by the practice.

Additional information or specific request (optional): _____

SENSITIVE INFORMATION AUTHORIZATION

I understand that my health record may include information relating to sexually transmitted disease, AIDS/HIV, behavioral or mental health services, and treatment for alcohol or drug abuse.

☐ YES, I consent to release of this information. ☐ NO, I do not consent to release of this information.

AUTHORIZATION TERMS

I understand that I may revoke this authorization at any time by providing written revocation to the individual or organization releasing the information. Revocation will not apply to information already released in response to this authorization, or when applicable law gives an insurer the right to contest a claim. Unless otherwise revoked, this authorization will expire on the date, event, or condition specified below. If none is specified, it will expire one year from the date signed. I understand that authorizing disclosure is voluntary; I may refuse to sign this authorization and need not sign it to receive treatment. I understand that information disclosed may be subject to redisclosure and may no longer be protected by federal privacy rules.

Expiration date, event, or condition (optional): _____

TEMPORARY RECORDS PROCESSING / PRACTICE TRANSITION

A \$25 records processing fee is required before records are released, except where a different fee is required by applicable law. During the transition of the practice records to UT Health, you may instead choose to wait until the transfer is complete and request your records from UT Health. UT Health will determine its own request process, timing, and any applicable fees.

SIGNATURE

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient (if legal representative): _____ Witness (if applicable): _____

Requests will be processed in accordance with applicable federal and Texas law.