CHARLES W. MONDAY, JR,. M.D., P.A.
130 Medical Center Parkway, Suite 6
Huntsville, Texas 77340
936-295-9101.....936-295-5977(FAX)

MEDICAL RECORDS & X-RAY RELEASE AUTHORIZATION

Records Being Requested From
__ Charles W. Monday, Jr. M.D., P.A.

Person/Physician, Facility and/or Company to whom information is to be released:
Name:_____
Address:_____

Records Being Requested From
_ Current Custodian of Records:

Custodians Name:_____
Address:_____
City:_____State:_____Zip:_____

Patient's Name:_____
Date of Birth:_____ Social Security #:_____

Information to be Released

Federal Regulation (42CFR Part 2) and/or Texas Law Article 4495b, Section 5.08

__Copy of Complete Health Record (Information obtained in the course of treatment from other hospitals, physician's offices, clinics, and other medical institutions etc. will not ne included, unless selected below.)

___ Release Only the Specific Records Checked:
__Physician Lab Notes __ECG/Non Invasive Cardiology Reports __Lab Reports
__X-ray Films __X-ray Reports __Other:_____
__Copies of Records From other healthcare facilities retained in Dr. Monday's Record

Purpose of Disclosure:
__Attorney/Legal __Continued Patient Care __Personal Use __Insurance Claim Processing
__Insurance Policy Approval __Worker's Compensation __Other:_____

SENSITIVE INFORMATION CONCERNING DIAGNOSIS, TREATMENT, AND/OR STATUS OF ACQUIRED IMMUNE DISEASE (HIV), SEXUALLY TRANSMITTED DISEASES, MENTAL CONDITIONS, AND/OR DRUG AND ALCOHOL ABUSE WILL BE RELEASED UNLESS SIGNED HERE:_____

I understand this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. It is further understood that information released is for the specific purpose stated above and may not be provided in whole of in part to any other agency, organization or person. I understand that correspondence, patient discharge instructions, and records from other health care providers will not be released with this routine request unless specifically requested above. This consent will expire 90 days after date of signature. Charles W. Monday, Jr., M.D., P.A. and employees are released from legal responsibility for the release of the above information to the extend indicated and authorized herein.
Signature:_____ Date:_____
Witness:_____Date:_____
Relationship to Patient:_____

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent any misunderstanding of the information that has been written in the record.
I will not hold Charles W. Monday, Jr., M.D., P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting physician for the correct interpretation.

Patient Signature:_____Date:_____