The Swamy Clinic PA
1111 Sara Swamy Drive • Sherman, TX 75090
Office: (903) 893-6311 Fax: (903) 870-0456

CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____
to release the following information from the health records of:

Patient Name:_____ DOB:_____

Patient Address:_____

- ☐ COMPLETE MEDICAL RECORDS
- ☐ EXCLUDING INFORMATION RELATED TO HIV AND/OR RESULTS
- ☐ HISTORY AND PHYSICAL ONLY
- ☐ OTHER:_____

Please release requested information to:

☐ The Swamy Clinic, P.A.
1111 Sara Swamy Drive
Sherman, TX 75090
Phone (903) 893-611
Fax (903) 870-0456
www.swamyclinic.com

☐ Other: _____

_____

_____

I understand that 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. The facility, it's employee's and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Witness Signature Date