TRUFORM
TEXAS FUNCTIONAL HEALTH CENTERS
FEEL. BETTER. FASTER.

411 N Washington Ave, Suite 7500, Dallas, TX 75246
Phone (469) 334-0624 | Fax (214) 269-7547
info@texasFHC.com

Medical Records Request

Authorization for Release of Protected Health Information

Use this form to request a copy of your medical records, or to authorize their release to another person or health care provider. Please complete every section, then sign and date the authorization on page 2. Submission instructions are at the bottom of page 2.

1. PATIENT INFORMATION

PATIENT FULL NAME

DATE OF BIRTH | PHONE | EMAIL

MAILING ADDRESS

CITY | STATE | ZIP

2. RECORDS REQUESTED

Date range of records requested:

FROM (MM/DD/YYYY) | TO (MM/DD/YYYY)

Type of records (check all that apply):

- ☐ Chiropractic / treatment records
- ☐ X-ray / imaging reports
- ☐ Billing / payment records
- ☐ Examination & evaluation findings
- ☐ Lab or diagnostic results
- ☐ Complete record

3. RELEASE RECORDS TO

- ☐ Send the records to me (the patient)
- ☐ Send the records to the person / provider below

NAME OF PERSON OR PROVIDER

ADDRESS

CITY | STATE | ZIP

PHONE | FAX / EMAIL

4. PREFERRED DELIVERY METHOD

- ☐ Secure email
- ☐ Mail to address above
- ☐ Pick up in person

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5. AUTHORIZATION & SIGNATURE

I authorize Texas Functional Health Centers to use or disclose the health information described in this form. I understand that this information may include records relating to my chiropractic and functional health care. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, by notifying the practice's Privacy Officer. Unless revoked earlier, this authorization expires one (1) year from the date signed below.

I understand that information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law. Texas Functional Health Centers will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. A reasonable, cost-based fee may apply for copies, as described in our Notice of Privacy Practices.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____ DATE _____

PRINTED NAME _____ IF SIGNED BY A PERSONAL REPRESENTATIVE, DESCRIBE AUTHORITY _____

How to submit this form: Return the completed, signed form to our front desk in person, by mail to 411 N Washington Ave, Suite 7500, Dallas, TX 75246, by fax to (214) 269-7547, or by secure email to info@texasFHC.com. Please allow up to 15 business days for processing.

FOR OFFICE USE ONLY

Received by	Date received
Identity verified (ID on file)	Released by / date