FOSSIL CREEK FAMILY MEDICAL CENTER
David Simonak, D.O. & Ryan Simonak, D.O.
7510 North Beach Street
Fort Worth, TX 76137
Phone: 817-498-1818 Fax: 817-581-3761

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Patient Name: _____

Previous Name, if applicable: _____

D.O.B.: _____ SSN: _____

Doctor/Clinic to provide records: _____
Name

_____ _____
Phone Number Fax Number

I hereby authorize the above Doctor/Clinic to release information available as to diagnosis, treatment, and prognosis with respect to the physical or mental condition and/or treatment on the above referenced patient and any other non-medical information of the referenced patient to **Fossil Creek Family Medical Center** at the above referenced address, or fax number.

_____ Covering periods from _____ to _____

_____ All Medical Records

_____ Other: _____

I KNOW that I am entitled to receive a copy of this authorization upon request.
I AGREE that a photocopy of this Authorization shall be as valid as the original
I ACKNOWLEDGE receipt of the Notice of Information Practices.
I KNOW that I may revoke this authorization at any time.
I AGREE this authorization will be valid for 90 days from the date above.

_____ I agree to the release of any psychiatric information that may be in my records.

_____ I agree to the release of any HIV/Sexually Transmitted Disease information that may be a part of my records.

_____ I agree to the release of any drug and/or alcohol information that may be in my records.

_____ _____
Patient Signature – List Relationship If Not Patient Printed Name