CALVARY MEDICAL CLINIC

"WHERE YOUR HEALING BEGINS"

RELEASE OF MEDICAL RECORDS

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Date: _____/_____/_____

To: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: (_____) _____-_____ **Fax: (_____) _____-_____**

I hereby authorize and request you to release the medical records including all HIV test results and any and all psychiatric and/or other mental health documentation on:

Patient:_____DOB: _____/_____/_____SS#: _____-_____-_____

Address:_____Phone #: (_____) _____-_____

City: _____ State: _____ Zip Code: _____

REASON FOR RELEASE OF INFORMATION:

✓ **Continuity of Care and/or Treatment**

✓ **At the request of the individual**

INFORMATION NEEDED:

_____All Medical Records **_____Hospital Stay**

_____Lab And/Or X-ray Reports **_____Hospital Discharge Summary**

_____Pathology Reports **_____Operative Reports**

_____Immunizations Only **_____Billing Records**

_____Last Notes For The Last 6 Months, Medication List, Problem List

Patient Signature: _____ Date: _____/_____/_____

Employee Name: _____ Date: _____/_____/_____

PLEASE MAIL OR FAX RECORDS TO:

Cleveland: 108 William Barnett Ave, Cleveland, Texas 77327

❍**Main Clinic: - Phone: (281) 592-9775 Fax: (281) 432-0548**

❍**Cleveland OB/GYN "Suite A": - Phone: (281) 593-1660 Fax: (281) 593-0730**

❍**Cleveland Annex "Suite B": - Phone: (281) 592-9775 Fax: (281) 592-5933**

Livingston: ❍ 309 Hwy 59 S. Loop, Livingston, Texas 77351 - Phone: (936) 327-1055 Fax: (936) 329-8800

Dayton: ❍ 205 N. Main, Dayton, Texas 77535 - Phone: (936) 258-5644 Fax: (936) 258-7292