Southern Horizon
HEALTHCARE
www.southernhorizon.org

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient's Name:_____

Address:_____

Phone:_____ DOB:_____ SSN:__XXX-XX-_____

Which records are needed:_____

Reason for transfer/request:_____

I, the undersigned, do hereby authorize and direct you to

( ) Furnish records **TO** Southern Horizon Healthcare from:
( ) Release records **FROM** Southern Horizon Healthcare to:

******IMPORTANT NOTICE: Per Southern Horizon Healthcare Practice Policy, we only copy, print, mail or fax SHH records. We do not copy, print, mail or fax other Doctor's medical records. Please contact your past doctor for these records.**

Write the Practice Name or Hospital Name/Physician name:

Name:_____

Address:_____

Phone:_____ Fax:_____

Check how records are to be received: Mail_____ Pick-Up_____ Fax___X_____

(If **all** records are requested, **Southern Horizon Healthcare will mail records**)

Southern Horizon Healthcare PLLC
2280 Highland Village Rd., Suite 100, Highland Village, Texas 75077
Phone 469-645-0200 Fax 469-320-9550

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that I am responsible for cost for copies.
A copy of this authorization is as valid as an original and will expire 6 months from the date below.

Medical Records Request Fees:

- **Print-** I understand that you may charge me a fee of up to $25 if I request my entire chart for personal use
- **Oversized Document-** I understand that you may charge me a fee of up to $30 if I request my entire chart for personal use and it exceeds 100 pages
- **NO CHARGE-** Any records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

I UNDERSTAND THAT SOUTHERN HORIZON HEALTHCARE DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS OR FACILITIES.

PRINT NAME: _____ DATE:_____

SIGNATURE: _____

WITNESS: _____