# AUTHORIZATION FOR
# RELEASE OF MEDICAL RECORDS

This authorizes **C. Funsho Fagbohun, MD, PhD, P.A., 1601 Liberty Street, Suite A, Richmond, TX 77469, Ph: 281-342-6962, Fax: 281-342-6963** to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

- ☐ Complete Record
- ☐ Records of care from the following dates: _________________ to _______________
- ☐ Records concerning the following conditions: _______________________________
- ☐ Other, please specify: ___________________________________________________
- ☐ Confer with the person(s) listed below orally about my medical information:

**HIV/AIDS**: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial**: __________ **Date**: _______________

**Release to the following person(s):**

**Name**: ____________________________________________________________________

**Address**: __________________________________________________________________

____________________________________________________________________

**Phone**: ______________________________ **Fax**: ________________________________

The reasons or purposes for this release of information are as follows:

__________________________________________________________________________

__________________________________________________________________________

**Patient's Name**: _____________________________________ **Date**: _________________

**Date of birth**: ____________________ **Social Security Number**: ______-_____-_______

**Patient's Signature**: _____________________________ **Witness**: ___________________

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.