LIFENET
6225 St. Michael Dr., Texarkana, Texas 75503 (903) 832-8531/Fax (903) 832-0215

Medical Records Release

Patients Name _____ Run Number _____

Date of Service or Treatment _____

Permission is granted to**:** **LifeNet, Inc.**

6225 St Michael Dr Texarkana TX 75503

To convey the information contained in my medical record to:
(requesting hospital, doctor, insurance, etc.) _____

_____
Address

I hereby authorize the above named source to release or disclose the following information for the period(s) identified above:

- All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, or drug/and or alcohol treatment, HIV/AIDS or sickle cell anemia.

I understand that this consent is subject to revocation by me at any time, except to the extent that action has been taken in reliance with the consent prior to revocation. In any event, this consent will expire ninety (90) days from execution.

_____ _____
Patient Signature Date

If the patient is a minor, deceased, or legally incompetent, a signature of the legally appointed responsible party is necessary below.

_____ _____
Responsible Party Date

_____
Relationship to patient

_____ _____
Witness Date