

JACINTO MEDICAL GROUP, P.A.

2800 GARTH ROAD, BAYTOWN, TX. 77520

PHONE: (281) 425-3800

DATE: _____

DEPARTMENT: (CIRCLE ONE) GROUP CORP BUC

PATIENT'S NAME: _____

PATIENT'S ACCOUNT #: _____

PAYER'S NAME: _____

CARD TYPE: _____

CREDIT CARD #: _____

EXPIRATION DATE: _____

CVM CODE (if available): _____

PATIENT'S ZIP: _____

AMOUNT PAID: _____

DOCTOR'S NAME: _____

PAYMENT TAKEN BY: _____

JACINTO MEDICAL GROUP, P.A.
Neurology, Family Practice, Radiology
2800 Garth Rd.
Baytown, TX 77521
281-425-3845 Fax: 281-425-3992

Date: _____

Re: _____

Case#: _____

To Whom It May Concern:

We have received your request for medical records on the above patient. Our fees for copying records are as follows:

_____ \$25 for first 20 pages and \$.50 for each additional page

_____ \$25 - Physician Form

_____ \$25 - Billing Records

_____ \$15 - Affidavits/Questionnaires

_____ \$7.50 (per sheet) X-Ray Films

_____ \$15 - Image Disc

of total pages copied _____

Total Payment Due \$ _____

It is our policy to obtain payment prior to releasing records. Should you require additional information, do not hesitate to contact our office. Your prompt attention to this matter will expedite your request and will be greatly appreciated.

Make checks payable to:

_____ Jacinto Medical Group, P.A. (Tax ID# 76-0488268)

_____ Jacinto Medical Corporation (Tax ID# 76-0380232)

_____ Baytown Urgent Care (Tax ID# 20-3893186)

Thank you in advance.

Custodian of Medical Records

JACINTO MEDICAL GROUP/MRI DIAGNOSTIC CENTER

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

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:** _____

Limitations on the information you may release subject to this Release Form are as follows:

Release my protected health information to the following person(s)/entity: (If these records are for another physician, we will send the records directly to the doctor you indicate below at no charge)

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

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

Continue Patient Care Attorney/Legal Insurance Purposes Personal Use

I understand that you will provide this information within 15 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. Our fees are as follows:

MEDICAL RECORDS:	\$25.00 for the first 20 pages and .50 for each additional page
AFFIDAVITS:	\$15.00
BILLING RECORDS:	\$25.00
X-RAY FILMS:	\$ 7.50 per sheet

Print Name _____ Date of Birth: _____

Patient SS# _____

Patient signature (or parent, guardian or legal representative):

Date: _____



JACINTO MEDICAL GROUP

2800 Garth Road, Baytown, TX 77521
Tel: (281) 425-3800 Fax: (281) 425-3992

MEDICAL RECORDS RELEASE FORM

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HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical records.
Initials: _____ Date: _____

I request the following information to be released:

Specific dates: _____

- Entire record
- History & Physical
- Discharge Summary
- Operative Report
- Lab/Pathology
- X-Rays, Ultrasounds, Diagnostic Testing
- Other: _____

Release my protected health information TO the following person(s)/entity:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____

Release my protected health information FROM the following person(s)/entity:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

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

- Continue Patient Care
- Insurance Purposes
- Attorney/Legal
- Personal Use

Print Name: _____ Date of Birth: _____

Patient SS#: _____

Patient Signature: _____ Date: _____

I understand that you will provide this information within 15 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