MEDICAL RECORDS REQUEST

Dear Dr. ____________________________:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

__________ Complete record

__________ Records of care from _____________________ to ________________ only

__________ Records of care concerning the following condition(s)

____

__________ Other. Specify: ____

__________ Confer with other person orally about information in my medical record

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 _____________________

to the following person(s):

William C. Biggs, MD FACE
Via Fax (Preferred): (806) 356-0045 **or Via Mail: William C Biggs MD FACE**
1215 S. Coulter Street, Ste 400
Amarillo, TX 79106

The reasons or purposes for this release of information are:

____

____

I understand that you will provide this information within 15 business days from receipt of request.

Signed:____ Date: ____________
(Patient or person legally authorized to consent on patient's behalf)