Gibbs Family Medicine
P.O. Box 750
Helotes, TX 78023

Authorization for Release of Medical Record

*Please **mail** this record request, along with payment.*

By signing, I authorize and request **Gibbs Family Medicine** to provide to me at the address listed below a copy of the **Entire Medical Record** for the purpose of continuing medical care. Medical records will be copied in electronic format and delivered via US Postal Service Certified Mail with Electronic Return Receipt. This authorization will expire in **one year**.

Patient Name	Date of Birth
Signature of Patient or Legal Guardian	Date
Printed Name of Legal Guardian (if applicable)	Relationship to Patient
Mailing Address	City, State, Zip Code

I understand that this medical record may contain reports, test results, and notes that only a physician can appropriately interpret. I understand and have been advised that I should contact a physician regarding the entries made in my medical record to prevent my misunderstanding of the information in these entries. I will not hold Matthew Gibbs, MD liable for any misinterpretation of the information in my medical record as a result of not consulting a physician for the appropriate interpretation.

The fee for providing these records is in accordance with Texas Medical Practice Act §165.2 and is as follows:

Select desired record format below								**Delivery**
☐ **CD** Copy of Entire Medical Record $ 25.00	**OR**	☐ **CD** Immunization Records Only $ 5.00	**OR**	☐ **Paper** Copy of Entire Medical Record $25.00 for first twenty pages, + $0.50 each additional page	**OR**	☐ **Paper** Immunization Records Only $ 5.00	**PLUS**	☑ **Mail** Postage & Handling (Certified Mail & Return Receipt) $ 5.00 for disc

All the medical charts for an entire family may be included on one CD, if so desired. Fill out a separate form for each family member.
The charge will be $25 for each chart, but only one Postage and Handling fee per disk.
All records are different lengths. If you choose to have a paper copy of your records,
the custodian of records will contact you by mail with the actual price, which will include increased postage due to weight.

Payment is accepted in the form of **Credit Card, Cashier's Check, or Money Order ONLY**.
Personal Checks will NOT be accepted. Do not send cash in the mail.

Credit Card Authorization Form			
Name:	Contact Phone:		
Billing Address:	City:	State:	Zip:
I hereby authorize Gibbs Family Medicine to charge the credit card listed below the amount of $			
Name on Card:			
Type of Card	☐ Visa	☐ MasterCard	☐ Discover
Card Number:		Exp: /	CVV code: _ _ _
I promise to pay such amount as noted above subject to and in accordance with the agreement governing the use of such card.			
Signature:		Date:	

Confidentiality Notice: *Unless otherwise indicated, the information contained in this facsimile is legally privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, copying, dissemination or the taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this communication in error, please immediately notify the sender by telephone and destroy the original message.*
Thank you, Matthew P. Gibbs, MD

OFFICE USE ONLY	V5	Date	Initials
	Request received:		
	Payment received:		
	Delivery:		