



NUVIA HEALTH

243 FM 1903, Suite 800 | Greenville, TX 75402
Phone: (903) 310-3231 | Fax: (346) 787-4951

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

SECTION 1 — PATIENT INFORMATION

Patient Full Name:		Date of Birth:	
Address:		Phone Number:	
City, State, ZIP:		Email Address:	
SSN (last 4):		Medical Record #:	

SECTION 2 — RELEASE FROM

Provider / Facility:	
Address:	
City, State, ZIP:	
Phone / Fax:	

SECTION 3 — RELEASE TO

Provider / Facility:	
Address:	
City, State, ZIP:	
Relationship:	

SECTION 4 — RECORDS REQUESTED

Type of Records (check all that apply): Complete Medical Records Referral Records Office Visit Notes Immunization Records Lab Results Billing Records Imaging / Radiology Prescription History Operative Reports Mental Health Records * Discharge Summary Substance Use Records *	Date Range: From: _____ To: _____ All Records
	Purpose of Disclosure: Continuing Medical Care Legal / Insurance Personal Records Other (specify): _____
Delivery Method: Pick Up in Person Mail to Address Above Fax to Number Above Secure Electronic	

* Additional consent may be required per state/federal law.

SECTION 5 — AUTHORIZATION & SIGNATURE

I understand that this authorization is voluntary and that I may refuse to sign. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this form. I may revoke this authorization at any time in writing, except to the extent that action has already been taken. This authorization expires one (1) year from the date signed unless otherwise stated.

Expiration Date (if other than 1 year): _____

Patient / Legal Representative Signature:	Date:	Relationship to Patient (if not patient):

SECTION 6 — FOR OFFICE USE ONLY

Received By:	Date Received:	Date Fulfilled:	Fulfilled By:	Status:
				Fulfilled Pending Denied

Notes:

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