Ike Eni MD PA
9319 PINECROFT SUITE 120
Ph: 936-321-1946 Fax: 936-321-8271
www.doctoreni.com

Medical Record Release

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Daytime Phone: _____

Please Check one:
I request and authorize EniHealthCare to: ☐ Release to ☐ Obtain from
my medical records from the organization or physician below:

Physician Name:/Organization Name:_____

Phone #:_____ Fax #:_____

You may disclose the following health care information:

☐ Medical Records ☐ Patient Visit Summary ☐ Imaging
☐ Immunizations ☐ Labs/Pathology ☐ EKG Reports
☐ Hospital Medical Records ☐ Other_____

I understand that this authorization will be kept in my file and will expire, without revocation, one year from the date of signing. I have authorized EniHealthCare to photocopy this authorization, and you may accept a photocopy as if it were the original. I understand that I may revoke this authorization in writing at any time except to the extent that action has been take based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I hereby release and hold harmless EniHealthCare from all liability and damage resulting from the lawful release of my Protected Health Information.

Specific Authorization

My health Information to be released MAY INCLUDE information that is related to sexually transmitted disease, HIV/AIDS, behavioral or mental health services, and/ or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked NO and initialed it.

Patient's Signature _____ **Date**_____