Vital Step Medical Center PLLC
2425 County Road 90, Pearland TX 77584
Phone: 281-997-7333 - Fax: 281-485-1146

AUTHORIZATION TO RELEASE/OBTAIN HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip: _____

I authorize the office Vital Step Medical Center PLLC / Simcare PLLC to (please check action):
Release or *Obtain* the following information from my medical records to or from (circle one):

Name of Person/Facility: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone: _____ Fax: _____

Please check information to be released (may contain information regarding drug / alcohol / psychological/ HIV-AIDS and/or communicable diseases):
__ Entire Record
OR
__ Laboratory Results __ EKG/Imaging Reports
__ Other Diagnostic Reports __ Progress Notes
__ Medication List __ Billing/Itemized Statement(s)
• Others Please Specify: _____
__ Include ALL Protected / Sensitive Records __ DO NOT include protected/sensitive records

The purpose for release of information is:
__ Personal Use __ Legal Purposes __ Insurance __ Medical Care
__ Social Security/Disability __ Other (Please Explain) _____

- I understand that this authorization is valid for one (1) year from the date of signature.
- I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been made before the receipt of revocation.
- Additionally, I understand that a fee for preparing and furnishing this information may be Charged according to ruling set forth by the Texas State Board of Medical Examiners.

Authorization to FAX medical records: __ Yes __ No

Please fax to: - **(281) 485-1146**

Patient Signature: _____ Date: _____

Signature of Parent/Legal Guardian: _____