NUVIA HEALTH

243 FM 1903, Suite 800 | Greenville, TX 75402
Phone: (903) 310-3231 | Fax: (866) 538-5188

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: Nuvia Health
Address: 243 FM 1903, Suite 800
City, State, ZIP: Greenville, TX 75402
Phone / Fax: (903) 310-3231 / (866) 538-5188

SECTION 4 — RECORDS REQUESTED

Type of Records (check all that apply):

- ☐ Complete Medical Records
- ☐ Office Visit Notes
- ☐ Lab Results
- ☐ Imaging / Radiology
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Referral Records
- ☐ Immunization Records
- ☐ Billing Records
- ☐ Prescription History
- ☐ Mental Health Records *
- ☐ Substance Use Records *
- ☐ HIV/AIDS-Related Records *

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

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

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):**