



**AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION**

I hereby request and authorize GASTROENTEROLOGY CLINIC OF SAN ANTONIO, P.A., located at 8550 Datapoint LL 100, San Antonio, Texas 78229, to release copies of my medical records to:

\_\_\_\_\_  
Name of person/organization to receive records

\_\_\_\_\_  
Address/City/State/Zip Code

**This authorization applies to all of the reports checked:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Admission Face Sheet      | <input type="checkbox"/> Problem List      | <input type="checkbox"/> Laboratory Results          |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Physician Orders  | <input type="checkbox"/> X-Ray Reports (type) _____  |
| <input type="checkbox"/> EKG                       | <input type="checkbox"/> Progress Notes    | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Discharge Summary         | <input type="checkbox"/> Medication Record | _____  |
| <input type="checkbox"/> Consultation Report       | <input type="checkbox"/> Pathology Reports | _____  |

Purpose of disclosure: (check all that apply)

Medical Care \_\_\_\_\_ Attorney \_\_\_\_\_

Insurance \_\_\_\_\_ Other \_\_\_\_\_

This authorization is valid for 90 days

**TO THE PARTY RECEIVING INFORMATION:** This information has been disclosed to you from the records whose confidentiality is protected by Federal Law. Federal Regulation (42CR, Part 2) prohibits you from making further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of medical information is not sufficient for this purpose.

I understand the records to be furnished or reviewed include information concerning my case history, examinations and treatment, including but not limited to any and all information related to HIV testing, diagnosis and treatment for acquired immune deficiency syndrome (AIDS) or related disorders, if any. I the undersigned understand this information may include reference to psychiatric treatment or testing, and evaluation or treatment for substance abuse. The health care facility, employees, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
**Signature of Patient** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/Guardian (if required)** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Witness** \_\_\_\_\_  
**Date**