Gastroenterology Clinic of San Antonio, P.A.

8550 Datapoint, Suite #200
San Antonio, Texas 78229
Phone – (210) 615-8308
Fax – (210) 615-8313

AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ _____ _____
Printed Patient's Name | Date of Birth | Identification Number

By signing this form, I authorize:

Name:_____
Address:_____
_____
Phone:_____
Fax:_____

To release to:

Gastroenterology Clinic of San Antonio
8550 Datapoint, Suite #200
San Antonio, Texas 78229
Phone: (210) 615-8308
Fax: (210) 615- 8313

the following individually identifiable health information about me: (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be releases, origin of information, etc.):

□ All medical information □ Radiology Reports □ Laboratory/Pathology Reports
□ Progress Notes □ Operative Reports □ Insurance Information
□ Other_____

Covering the period(s) of care from _____ to _____.

I understand that information relevant to HIV testing and/or AIDS related diagnosis(es) may be contained in this information. I understand this information may also include reference to psychiatric treatment or treatment for substance abuse.

The information will be used or disclosed for the following purpose(s):

□ Personal □ Continued Medical Care □ Insurance Claim
□ Legal □ Disability Claim □ FLMA
□ Other_____

This authorization will expire on:_____ not to exceed 24 months.

I understand that I have the right to inspect and copy my own protected health information to be used or disclosed under this authorization. Gastroenterology Clinic of San Antonio will not receive payment or other remuneration from a third party in exchange for using or disclosing this information. I also understand that I do not have to sign this authorization in order to receive treatment from Gastroenterology Clinic of San Antonio. In fact, I have the right to refuse to sign this authorization. When my information is used to disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient authorization in writing except to the extent that Gastroenterology Clinic of San Antonio has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address above.

Signed by: _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Printed Name of Legal Guardian (if applicable) | Date Signed