Authorization for Release of Medical Information

Patient Full Name: _____ DOB: __ __/__ __/__ __

Previous/Other Name: _____ (If different than patient listed above)

This will authorize:

Name: _____

Address: _____

City, State, Zip: _____

To Release to:
Heart Clinic of San Antonio, PA
502 Madison Oak, Suite 250
San Antonio, TX 78258
210.483.8883 phone
210.494.1740 fax

GENERAL INFORMATION REQUESTED

Medical Information Requested:

Most Recent

- Progress note
- Diagnostic testing
- Medication list
- Labs

Reason for Release:

- Continuation of care

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

YES	NO	
☐	☐	Substance Abuse (alcohol/drug abuse)
☐	☐	Mental Health/Depression (includes psychological testing)
☐	☐	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information.

Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:

The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required by or permitted by law.

_____ _____

Signature of patient or authorized representative: Witness:

Date: __ __/__ __/__ __ Date: __ __/__ __/__ __