MacGregor
Medical Center - San Antonio

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Incoming Request for Medical Records

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I request and authorize *___________________________________

(address:____)

to disclose certain protected health information about me to MacGregor Medical Center of San Antonio.

This authorization permits MacGregor Medical Center of San Antonio to use 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 released, origin of information, etc.):

*____

____

____

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

*____

(If requested by the patient, purpose may be listed as "at the request of the individual.")

The time period for information covered by the release is from:*___________ to:__________.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. **This authorization will expire on *_______________.** {Expiration Date or Defined Event}. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address in the heading.

*______________________________ ____________
Printed Name of Patient Date of birth

*______________________________ *____________
Signature of Patient or Legal Guardian Date

______________________________ ______________________
Printed name if not patient Relationship to Patient

*required information FOR MMC USE ONLY: MR#:____________ March 2003