



Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name: _____ **Date of birth:** _____

1. The following information is to be released, including any limitations on what may be released:

2. The time period for information covered by the release is from: _____ **to:** _____

3. You may release my protected health information to the following person(s)/entity:

Name: _____

Street: _____

City: _____ **State:** _____ **Zip code:** _____

4. The reason(s) or purpose(s) for this release of information is/are as follows:

5. This authorization shall be in force and effective until the following event and/or date:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice: Holly Williamson, (210) 581-8208, fax (210) 581-8209.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy, and the policy itself may provide the insurer with such a right.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Patient Signature (or parent, guardian or legal representative)*

Date

*include printed name if you are not the patient, and how you are entitled to represent the patient.

FOR MMC USE ONLY: MR#: _____