Medical Center – San Antonio

9969 Fredericksburg Rd, San Antonio, TX 78240-4106 (210) 690-2273 fax (210) 581-8216

Medical Records Release Restriction Form

By signing this form, you authorize us to restrict confidential health information about you to the person(s) or entity listed below. You have the right to request restrictions on the use and disclosure of my health information for treatment, payment or health care operations purposes or notification purposes. MacGregor Medical Center – San Antonio (MMC) is not required to agree to your request. If MMC does agree to a restriction, it will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment.

Patient Name:____ **Date of birth:** ______________

1. The following information is to not to be released, including any limitations on what may be released:

____

____

2. The time period for information covered by the restriction is from: ___________ **to:** _____________

3. You may not 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 restriction 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.

Approved by Board of Directors 10/21/10