MacGregor
Medical Center - San Antonio
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San Antonio, TX 78240-4106
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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.):

*_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

>___Yes, I consent to the release of this information.__No, I do not consent to the release of this information.<

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}.

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 the 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. 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#:_____ February 2017