San Marcos Family Medicine
2406 Hunter Rd # 106 San Marcos, TX 78666
Phone (512) 396-7686 Fax (512) 396-8006

RELEASE OF MEDICAL RECORDS

1. Patients Information

Name: _____
Address: _____
_____
SSN: _____
D.O.B _____

2. Authorization for Release

I hereby authorize:

Name: _____ Phone _____

City, State, Zip_____ Fax _____

To release, disclose, and deliver the medical information described below to :

Name: _____ Phone _____

City, State, Zip _____ Fax _____

Please release the following:

_____ Last ER visit _____Progress notes ____History/Physical _____Laboratory
_____Immunization record _____ EKG/ECG ____Radiology _____ All Records

3. SPECIFIC AUTHORIZATION

I Specifically authorize the release of all medical information relating to the above named patient including but not limited to the following categories protected by state of federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS related information, if such information is contained in the records. This request includes any report, correspondence, test results, and any other information contained in the records, whether generated by the authorized provider or another entity.

4. VALIDITY

I understand that this authorization will automatically expire one year from date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above, I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality,

I authorized the release of the information as indicated above.

_____ _____

NAME **DATE** **WITNESS** **DATE**