Authorization to Release Medical Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of medical records. Covered entities, as that term is defined by HIPAA and relevant state law, must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's PHI. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law.

Information regarding the patient for whom the authorization is made:

Patient Name: Date of Birth: mm/dd/yyyy

Address:

Contact phone: Email:

Release my information ○ **from** ◉ **to**

Integrative Family Medicine
18720 Stone Oak Parkway Suite 201
San Antonio, TX 78258
P: (210) 888-1817
F: (210) 908-5943

Release my information ◉ **from** ○ **to**

Facility/Physician Name:

Address:

City, State Zip:

Contact Phone:

Contact Fax:

REASON FOR DISCLOSURE

- ☐ Treatment/Cont. Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first item.

- ☐ All Health Information
- ☐ Medical Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other

Your initials are required to release the following information:

☐ Mental Health Records (excluding psychotherapy notes)

- [ ] Drug, Alcohol, or Substance Abuse Records
- [ ] Genetic Information (including Genetic Test Results)
- [ ] HIV/AIDS Test Results/Treatment

The individual signing this form agrees and acknowledges as follows:

i. Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will NOT be conditioned upon my signing of this authorization form.

ii. Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): MM/DD/Y` .

iii. Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

iv. Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION ONLY if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

v. Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Name: Date: MM/DD/Y`

Please sign with mouse or finger:

Clear Signature