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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Release records to (name and address):

Release records from: (name and address)

Phone: _____ Fax: _____

Phone: _____ Fax: _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND SPECIFY BELOW THE INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR COMPLETE RECORDS WILL BE RELEASED.

I authorize the health care provider to release the information specified to organization, agency, or individual(s) named on this request with the EXCEPTION of substance abuse, psychological or psychiatric conditions, AIDS/HIV, etc. **Please specify:** _____

***REASON FOR RECORDS RELEASE (If moving, provide forwarding address):**

*It is our goal to improve our practice and better serve our patients. We appreciate your comments,

I understand that I may revoke this authorization at any time and that unless and earlier date is specified it will automatically expire 12 months after the date affixed below. **Treatment, payment, enrollment or eligibility of benefits** are not conditioned on signing the authorization or description of the consequences to the patient if her or she refuses to sign the authorization. Once the information is used or disclosed, it may no longer be protected. A copy of this authorization may be utilized with the same effectiveness as an original. My signature below, indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release.

Signature

Date

Relationship to Patient