**Authorization to Release Health Care Information**

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:**\_\_\_\_\_\_\_\_\_\_\_\_**SSN:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the following Physician/Clinic to release my complete medical records to:

**Dr Daniel Garcia East Belt Family Medicine 5402 E Sam Houston Pkwy N Houston TX 77015.**

**Physician Name/Clinic:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Fax:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize **Dr Daniel Garcia** to release my complete medical records to:

**Physician Name/Clinic:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Fax:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The reason or purpose for this release or information is for continuity of car**e:

**Please include the follow information:**

* **Complete Medical Record**
* **Consultation, History & Physical, Progress Notes**
* **Laboratory Studies**
* **Imaging Studies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that my expressed consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use), you are specialty authorized to release all health care information relating to such diagnosis, testing, or treatment.

**Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_.**

I, the undersigned, have read the above and authorize disclosure of such information as herein contained. I have the right to revoke this authorization in writing any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may not longer be protected. I hereby release and hold harmless the above named facility and its parent company form all liability and damage resulting from the lawful release of my Protected Health Information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Signature Date Witness Signature Date