AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB:_____ / _____ / _____
(Please Print Full Name)

By signing this form, I authorize: **Marcos Medical Care**
510 Med Court, Suite 210
San Antonio, Texas 78258
Phone: (210) 494-4290, Fax: (210) 494-4809

TO RELEASE TO:

Physician(s) Name & Address: _____
(Write "Self" if you are taking your medical records)

Phone: _____ Fax: _____

I, _____, hereby authorize Marcos Medical Care to release and disclose the protected health information described below. (Specifically describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.):

- ☐ All Records
- ☐ Radiology Reports
- ☐ Laboratory/Pathology Reports
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Other: _____

The information will be used or disclosed for the following purpose:

_____

(If requested by the patient, purpose may be listed as "at the request of the individual.")

This authorization shall be in force and effective until the following event and/or date: _____.
(If authorization is for research, "end of research study," "none," or similar language is sufficient.) (If no date is specified, this authorization will become invalid after 1 year).

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Marcos Medical Care. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- The practice will not condition your treatment, payment, enrollment in a health plan or eligibility for benefits on whether you provide authorization for the requested use or disclosure unless it is research related treatment and the use or disclosure is for Protected Health Information for such research or the health services are solely for the purpose of creating Protected Health Information for disclosure to a third party and the authorization is for disclosure to such party.
- You may inspect a copy of the Protected Health Information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed Authorization.

I understand that information relevant to HIV testing and/or AIDS related diagnosis/diagnoses may be contained in this information. I understand this information may also include reference to psychiatric treatment or substance abuse.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I also understand that I do not have to sign this authorization in order to receive treatment from Marcos Medical Care.

_____ _____
Signature of Patient/Legal Guardian **Date**

_____ _____
Print Name (Legal Guardian if applicable) **Relationship to Patient**