Medical Records Release Authorization

Patient Name:	DOB: / /
Address:	Phone Number:

From: ____/_____/_____ To: _____/_____/_____ or **ALL Records**

Concerning (diagnoses, illness, treatment, health maintenance) or other _____

HIV/AIDS: I consent to the release of any positive or negative test results of AIDS or HIV infection, antibodies, or infection with any other causative agent of AIDs with the rest of my medical records. Initial: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

I authorize you to release my protected health information from the following person(s)/entity:

From:	To New Physician:
Helotes Pediatrics, P.A. 11085 Bandera Rd., Ste 102 San Antonio, TX 78250	_____ _____

The reasons or purposes for this release of information are as follows:

____ Change of Physician	_____ Relocation/Moving	_____ Other

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient / Parent Printed Name:

_____ **Date:** _____/_____/_____

Patient / Parent Signature: _____

I understand that you will provide this information within 15 days from receipt or request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas State Board of Medical Examiners

This form provided by
Helotes Pediatrics, PA 11085 Bandera Rd. Ste 102. San Antonio, TX 78250
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