Helotes pediatrics

Medical Records Release Authorization From Helotes Pediatrics

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.

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

Records for _____ (Name) _____ (DOB) obtained/created during the period

_____ (Date) to _____ (Date)

concerning (diagnoses, illness, treatment, health maintenance)

or other _____

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:

Helotes Pediatrics, PA
11085 Bandera Rd. Ste. 102
San Antonio, TX 78250
Phone: (210) 372-0505
Fax: (210) 372-0404

Please release to:

_____

Doctor, Clinic, or Hospital

_____

Street Address/Suite City State Zip

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

_____

_____

Patient signature (or parent, guardian or legal representative):

_____

Date: _____

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.