Aguilar Family Health Care

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ Date of Birth_____

Patient Name

_____

Patient's Street Address City and State Zip Code Phone Number(s)

For the Patient: I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter 1, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that I may revoke this authorization at any time by notifying Aguilar Family Health Care in writing. However, the revocation will not have an effect on any actions Aguilar Family Health Care took before receiving the revocation.

********I understand that this authorization will expire one year from the date of the signature**********

Patient/Legal Representative Signature: _____ Date_____

PATIENTS, PLEASE DO NOT WRITE BELOW THE DOUBLE LINES. THIS IS FOR AFHC STAFF ONLY. THANK YOU.

==========

I authorize Aguilar Family Health Care to receive my protected health information from:

Name of Person or Group: _____

Fax & Phone Number: _____

I hereby request and authorize you to release copies of all medical records concerning treatment including:

- ☐ Last three office notes
- ☐ Initial Evaluation
- ☐ Medication List
- ☐ MRI Report/CT Report/X-ray Report/Lab Report (Most Recent)
- ☐ Other_____

Aguilar Family Health Care Contact Person: _____Date of Request: _____

Please forward all requested medical information to:

Aguilar Family Health Care
3303 Rogers Road, Ste 130
San Antonio, TX 78251
Phone: 210-520-2224 Fax: 210-520-2238