MEDICAL RELEASE AUTHORIZATION

____
Name of Patient (Please Print) Date of Birth

____
Street Address City, State, Zip Phone

____
Social Security #

I hereby authorize (Please Print Doctors name and information)
____
____
____

To release to:
Alamo Heights Primary Care Physicians
250 E. Basse Rd Suite 208
210-226-2424 O, 210-226-6567 F

I consent to release all the medical information regarding my treatment or hospitalization from my:

- General hospitalization or outpatient care
- Drug and alcohol treatment care
- Emergency room visit
- Psychiatric care
- Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

***requires special consent**

I am requesting the following information from my records (check all that apply):

- Complete Health Record(s)
- Abstract of record (includes: History & Physical, Operative Report, Laboratory Report, Radiology Reports, Consultations, Discharge summaries, and other significant findings
- Labs
- X-rays

I permit this confidential information to be released for the following purpose:

- Continuing medical treatment

The date, extent or condition upon which this authorization expires is 90 days not to exceed 24 months (except for research purposes, state **"NONE"** for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations
I hereby authorize the release of all necessary medical records to Alamo Heights Primary Care Physicians. Please forward as soon as possible

____ ________________
Signature of patient or patient's representative Date

Printed name of patient's representative_____________________________________
Relationship to patient__________________