PALM VALLEY MEDICAL CLINIC, P.A

NOEL LOPEZ, M.D.

PATIENT RELEASE OF HEALTH INFORMATION AUTHORIZATION FORM

_______________________________ Patient Name

_______________________ DOB

☐ From: ☐ To:	Palm Valley Medical Clinic Noel Lopez, M.D. Lisa Guzman, PA-C Linda Garcia, P.A - C 5140 N. 10th St McAllen, TX 78504 P: (956) 972-1600 F: (956) 213-8577 (Medical Records)	☐ From: ☐ To:	______________________ Name / Entity ______________________ Address ______________________ City, State ______________________ Phone # / Fax#

Information to be released

☐ Complete Medical Records (if over 50 pages, please mail to the address above)

☐ Records of care from ___________________ to_________________ only.

☐ Records of care concerning the following condition(s):_______________________________

☐ Other Specify:____

____

Purpose of Request /Disclosure

☐ Treatment or Consult

☐ At request of the Patient

Drug and/or Alcohol Abuse, and/or Mental Health/Psychiatric, and HIV /AIDS Records Release

I acknowledge, and herby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

Initial: __________

Time Limit & Right to Revoke Authorization

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked this authorization will expire on the following date___________. If I fail to specify a date, this authorization will expire in six months. (TEX H&S 166.155)

Re-disclosure

I understand that the information disclosed by my authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information to the extend indicated and authorized herein.

Signature of the Patient or Personal Representative Who May Request Disclosure

I authorize ______________________________ to release the protected health information specified above.

Signature ___________________________________ Date_________________