VILLAGE CROSSING
WOMEN'S HEALTH
Join the Family

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print): _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM: _____

TEL: _____ FAX: _____

TO:
Village Crossing Women's Health
1139 E. Sonterra Blvd., Ste 260 San Antonio, TX 78258
210-404-2800**Fax 210-404-2803

Medical records requested: _____

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS; Village Crossing Women's Health, its employees and physicians are released from legal responsibility or liability for the release of the authorized information. If such information is contained in my medical records, I voluntarily authorize the release as authorized above of my test results for the human immunodeficiency virus (HIV), which is the probable causative agent of acquired immune deficiency syndrome (AIDS). I also voluntarily authorize release of my records related to communicable disease, drug, alcohol, and/or mental health diagnosis and treatment. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred. This consent is considered valid for one (1) year from the date this document is signed.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient: _____ Date: _____