VICTORIA WOMEN'S
CLINIC
(361) 578-5233 Fax (361) 573-5803
1-800-747-0819

Authorization to Release Information to Family Members/Friends

I, _____ authorize The Victoria Women's Clinic to release my records and any information requested to the following individuals:

Name(s): **Relationship:**

_____ _____

_____ _____

_____ _____

Health Information to be disclosed (Check all that apply):

___ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions)

OR

___ My complete health record, as above, with the exception of the following information:

____ Mental Health Records
____ Communicable Disease (including HIV and Aids)
____ Alcohol/Drug Abuse
____ Other (please specify) _____
_____

This authorization shall be effective until (Check One):

___ All past, present and future periods, OR
___ Date or Event: _____
unless I revoke it (NOTE: You may revoke this authorization at any time by notifying your health care providers)

_____ _____

Name of Individual giving this Authorization (Print) Signature of Individual giving this Authorization/ Date