



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

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