



SOUTH TEXAS MEDICAL CLINICS, P.A.
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

I hereby authorize:

To release information to:

Mail to:

Fax to:

The following information:
to be released:

The information is from the dates of _____ to _____

The purpose for the release
of this information:

This consent and authorization includes, for the period indicated, those care and treatment records designated, pertaining to: physical illness; emotional/mental illness; AIDS/HIV test results, diagnosis, treatment or related information (if any); and/or alcohol and drug abuse.

PATIENT'S NAME:

(Please Print)

PATIENT'S ADDRESS:

DATE OF BIRTH:

PATIENT'S SIGNATURE:

(If parent or guardian, relationship to patient)

DATE:

PLEASE ADDRESS ALL CORRESPONDENCE TO MEDICAL RECORDS DEPARTMENT

- 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 HIPAA privacy regulations.
- I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire ninety (90) days from the date of my signature.
- I understand that STMC may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for the Release of Information. I can inspect or copy the protected health information to be used or disclosed. I authorize STMC to use and disclose the protected health information specified above.