MacGregor
Medical Center - San Antonio
9969 Fredericksburg Rd
San Antonio, TX 78240-4106
(210) 690-2273 fax (210) 581-8216

Medical Records Release Form

I authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Date of birth:_____

You may release my protected health information to the following individual or organization.
(This includes verbal release of information, such as to a family member. The records may be released electronically.)

Name:_____

Address:_____

For the purpose of: _____

The following information may be released: entire record_____ or:

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

>__Yes, I consent to the release of this information.____No, I do not consent to the release of this information.<

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice: Connie Garcia, (210) 581-8208, fax (210) 581-8209.
I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy, and the policy itself may provide the insurer with such a right. I understand that the 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. The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Connie Garcia, at (210) 581-8208, fax (210) 581-8209.

The information covered by the release is from:_____ to:_____ (dates)

Unless otherwise revoked, this authorization expireds upon completion or upon the following event and/or date:_____

_____ _____
Patient Signature (or legal representative) **Date**

_____ _____ _____ _____
Name, if not the patient | Relationship, if legal representative | Witness signature | Witness name

FOR MMC USE ONLY: MR#:_____