St. Joseph Physician Associates

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV / AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any causative agent of AIDS with the rest of my medical records.
Initial: _____ **Date:** _____

Records to be released (as indicated by the checkmark(s) below)

___ Complete record
___ Records of care from the following dates: _____ to _____
___ Records concerning the following conditions: _____
___ Other, please specify: _____

Limitations on the protected health information you may release subject to this Release Form are as follows:

_____

_____

_____

Release my protected health information to the following person(s)/entity:

_____

The reasons or purpose for this release of information are as follows:

_____

_____

_____

Patients' Printed Name: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Patient's Signature (or parent, guardian or legal representative):

_____ Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.