COMPLETE THIS SHEET ONLY IF YOU WOULD LIKE US TO REQUEST MEDICAL RECORDS FROM A PREVIOUS PHYSICIAN

AUTHORIZATION FOR USE AND/OR
DISCLOSURE OF PROTECTED HEALTH INFORMATION
MEDICAL RELEASE

***Patient Information*:**
Full Name: _____ DOB: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ Home Telephone: _____

Information to be released – covering the periods of health care.
Facility: _____
Address: _____
Phone: _____ Fax: _____
____ All Medical records or from: (date) _____ to: (date) _____
____ All medical records except those pertaining to psychiatric visits HIV/AIDS testing and treatment, and drug and alcohol testing and treatment.
____ Only medical records pertaining specifically to: _____.

I do hereby authorize the release of the following described medical records to the facility listed below.

Dr. Renato A. Geralde, D.O., MBA
Dr. Manuel S. Naron, M.D.
Dr. Dean A. Earp, M.D.
150 E. Sonterra, Suite 220
San Antonio, TX 78258
PH: 210-481-6800 FAX: 210-481-1444

Except to the extent that action has already been taken in reliance to this authorization. I can, at any time, revoke this authorization by submitting a notice in writing to the Privacy officer of North Hills Family Medicine, office of Dr. Renato A. Geralde. Unless revoked, this authorization will expire on the following date or event _____ 180 days from the date of signature.
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This Facility, it's employees, officers and physicians are hereby released from any legal responsibility or liability of information to the extend indicated and authorized herein.
I understand that I do not have to sign this authorization, and my treatment or payment of services will not be denied if I do not sign this form. I may request a copy of this authorization.

_____ _____
Signature **Date**

_____ _____
Name of Patient Representative **Relationship to Patient**