Patient Authorization for Release of Protected Health Information

Patient Name:	DOB:
Phone:	Address:

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (45 CFR-164.508).

I hereby authorize to Release to:

_____ _____
_____ _____
_____ _____

Medical Records covering the period from _____ to _____ for the purpose of _____.

I understand that the information in my health records include information related to sexually transmitted disease (AIDS), (HIV). It may also include information about behavioral, or mental health services, and treatment for alcohol and drug abuse.

This authorization is valid until _____.

Under the Privacy Rule, I have the right to revoke this authorization at any time. If I withdraw my permission, my information may no longer be used or released for the reason covered by this authorization. However, any disclosures or actions initiated prior to my revocation may be completed by the individual or organization named in this authorization.

I must revoke this authorization in writing and send the revocation to: **SAN ANTONIO PEDIATRIC ASSOCIATES, P.A.**

☐ 315 N. San Saba, Ste.1075
San Antonio, TX 78207
(210)223-3543
Fax (210) 227-0282

☐ 5407 Walzem Rd.
San Antonio, TX 78218
(210) 646-8833
Fax (210) 646-9606

☐ 20627 Huebner Rd, Ste. A101
San Antonio, TX 78258
(210) 495-3947
Fax (210) 481-9027

☐ 730 N. Main, Ste. 224
San Antonio, TX 78205
(210) 225-2971
Fax (210) 225-1175

☐ 1730 SW Military Dr., Ste. 105
San Antonio, TX 78221
(210) 924-7645
Fax (210) 924-5611

☐ 215 N. San Saba, Ste. 101
San Antonio, TX 78207
(210) 223-2811
Fax (210)223-2996

☐ 9793 Culebra, Ste. 105
San Antonio, TX 78251
(210) 681-6439
Fax (210) 681-9922

Unless revoked earlier or otherwise specified above, this authorization will automatically expire one year from the date I signed this authorization.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization.

_____ _____
Print Name Date

_____ _____
Signature of Patient or Legal Representative Relationship to patient

_____
Witness