AUTHORIZATION TO RELEASE MEDICAL RECORDS

Port Lavaca Clinic Associates, P.A.
1200 N. Virginia St. Port Lavaca, Texas 77979
361-552-6721 Fax 361-552-7463

PATIENT'S NAME: _____ Telephone #: _____

Date of Birth: _____ Social Security #: _____

I authorize that my medical records be released:

FROM: _____ **To:** _____
(Name of provider/facility) (Name of Provider/Facility)

Phone#_____ Phone#_____

Fax# _____ Fax# _____

Please provide a copy of the summary or narrative of the following contents of my medical records (check all appropriate items that are to be copied/sent): _____ Office notes _____ Lab results _____ Complete set of medical record
_____ Other, please specify; _____

____ For care provided for these dates _____ to _____

____ Records of care concerning the following condition(s)

_____

Please check:

___ HIV / Aids. I consent the release of any positive or negative tests results for Aids or HIV infection. antibodies to Aids or infection with any other causative agent of Aids with the rest of my medical records.

Upon receipt of payment, the records will be: ____ Mailed
____ Picked up in person (you will be called when records are ready)
or
____ Can be electronically provided to you, via the Patient Portal.
Must have current "Informed Consent to use Patient Portal" on file.

PATIENT PRIVACY **PLEASE READ CAREFULLY**
By signing this authorization, you acknowledge that you have READ and SIGNED our Patient Registration Form & Notice of Privacy Practices form here at Port Lavaca Clinic and that you have received a copy of out Notice of Privacy Practices form. I understand that my healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations. The medical information obtained WILL NOT be re-disclosed to any other provider(s) or said patient. I waive any doctor-patient privilege that I have to said person or entity making this request. I understand that I have the right to revoke this authorization, in WRITING, at any time by sending written notification to Port Lavaca Clinic. A verbal revocation is NOT adequate to revoke this authorization. I am aware that I have the right to receive a copy of this release. Port Lavaca Clinic will not be liable for any released information made prior to receipt of revocation from patient. I understand that I have access to all personal medical records during normal business hours. I ALSO UNDERSTAND THAT MEDICAL RECORDS WILL BE PROVIDED NO MORE THAN 15 BUSINESS DAYS FROM RECEIPT OF REQUEST AND A FEE FOR PREPARING & FURNISHING THIS INFORMATION MAY BE CHARGED.

_____
(Patient's initials)

_____ DATE:
PATIENT SIGNATURE