# Authorization to Release Patient Health Information

Madison Oak Drive ●Suite 220 ● San Antonio, TX 78258 Phone: (210) 494-7979

Patient Legal Name: _____Phone Number: (_____) _____

Date of Request: _____Date of Birth: _____

Social Security Number: _____Date Needed: _____

| **Release information *from*:** | **Release information *to*:** |
|---|---|
| □ Dr. George Tuchsen<br><br>Madison Oak Drive STE 220<br>San Antonio, Tx 78258<br><br>Phone: (210) 494-7979<br>Fax: (210) 494-7980 | _____<br>Organization/Person Name<br><br>_____<br>Street Address<br><br>_____<br>City, State, Zip<br><br>_____<br>Telephone<br><br>_____<br>Fax Number |

TYPE OF RECORDS REQUESTED **(Charges for copies of records may be associated with your request)**

□ Entire Clinical Record
□ Laboratory/Diagnostic tests
□ X-ray Films
□ Other_____

**Sensitive records may require patient authorization.**
Please initial the appropriate records requested.
_____ Drug and/or Alcohol Abuse
_____ Mental Health (may include Pain Management or Psychiatry records)
_____ Sexually Transmitted Diseases (including AIDS/HIV)

Purpose or need for records:
□ Continuing care □ Copies for my own use □ Other_____

**Patient Rights:**
I understand that I have the right to revoke this authorization, *in writing*, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, I can write a letter to the person or entity holding the authorization, providing details of the date and content of the original authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may not longer be protected by federal or state law. I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization.

_____ _____ _____
Date Signature of Patient or Representative Relationship to Patient