

# McALLEN SURGEONS, L.L.P.

1801 South 5th Street, Suite 120

McAllen, Texas 78503

## General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize the custodian of records of: \_\_\_\_\_ or other person/entity (specifically describe) \_\_\_\_\_ to disclose/release the following information\* (check all applicable):

- |   |  |
|---|--|
| <input type="checkbox"/> All records                  | <input type="checkbox"/> Abstract/Summary                    |
| <input type="checkbox"/> Laboratory/pathology records | <input type="checkbox"/> Pharmacy/prescription records       |
| <input type="checkbox"/> X-ray/radiology records      | <input type="checkbox"/> Other (describe specifically) _____ |
| <input type="checkbox"/> Billing records              |  |

*\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): \_\_\_\_\_

Please send the records listed above to (use additional sheets if necessary):

Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

The information may be used/disclosed for each of the following purposes:

- |  |  |
|--|--|
| <input type="checkbox"/> At my request (only the patient can check this box) | <input type="checkbox"/> For employment purposes |
| <input type="checkbox"/> For my health care                                  | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> For payment/insurance                               |  |

This authorization shall expire no later than: \_\_\_\_/\_\_\_\_/\_\_\_\_ or upon the following event \_\_\_\_\_ (whichever is sooner), and may not be valid for greater than one year from the date of signature for records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

\_\_\_\_\_  
Signature of patient (or patient's personal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient representative

\_\_\_\_\_  
Representative's authority to sign for patient, (i.e parent, guardian, power of attorney for healthcare, executor)