
## 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 IMFORMATION MEDICAL RELEASE

***Patient Information:***

**Full name: _____ DOB: _____/_____/_____**
**Home Address:_____**
**City: _____ State:_____ Zip:_____**
**Social Security #:_____ Primary Telephone:_____**

***Information to be released – covering the periods of health care.***

**Facility: _____**
**Address: _____**
**Phone: _____ FAX: _____**

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

- ❑ **All Medical records <u>or</u> from: (date)_____ to (date) _____**
- ❑ **All Medical records <u>except</u> those pertaining to psychiatric visits, HIV/AIDS testing and treatment, and drug and alcohol testing and treatment.**
- ❑ **Only medical records pertaining specifically to: _____.**

**ATTENTION MEDICAL RECORDS: Please DO NOT fax a chart greater than 25 pages.**

**Please mail to address 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 extended 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**