Hill Country Medical Associates

774 Landa Street, New Braunfels, TX 78130
Phone: (830) 625-0305 Fax: (830) 625-0298

Medical Records Release Form

Patient's Name: _____ Date of Birth: _____/_____/_____

Social Security # (last 4): XXX-XX-_____ Phone: (H or C) (____)_____ (W) (____)_____

By signing this form, I authorize ***(Release From)***:

Facility/Doctor: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV / AIDS: I consent to the release of any positive or negative test 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:
Initials: _____ **Date:** _____

Mental Health/Substance Abuse: I consent to the release of any medical records related to treatment for mental health and/or substance abuse with the rest of my medical records:
Initials: _____ **Date:** _____

Please release the following records *(Please specify dates):*_____

☐ History and Physical ☐ Lab Results ☐ X-Ray _____

☐ Shot Record ☐ Office Notes ☐ Other _____

Please release my protected health information to the following person(s)/entity ***(Release to)***:

Facility/Doctor/Individual: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: (_____)_____ Fax: (_____)_____

The purpose/reason for this release of information are as follows:

☐ Continuing Care/Referral ☐ Transfer of Care ☐ Insurance

☐ Attorney/Court Case ☐ Worker's Compensation ☐ Personal Reasons

☐ Other _____

Please provide the requested records as follows:

1) ☐ Paper ☐ CD/DVD (minimum of 10 pages required)

2) ☐ Send by mail ☐ Fax to: (_____) _____-_____ ☐ Will pick up at office

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

This authorization shall be in force and effective for 180 days or until the following event and/or date:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice (to the address listed at the top of this form):

Douglas Brandsma
Privacy Officer

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority