2829 Babcock, 236C | San Antonio, TX 78229 | 210-298-9901 210-298-9909 (fax)

REQUEST FOR MEDICAL RECORDS

Patient Information

Name: _____

DOB: _____

Phone:_____

Information Released From

Name:_____

Phone: _____

Fax: _____

Please release the following health information to Alamo Family Practice:

Covering the periods of: All _____ or (date)_____ to (date)_____
Please check type of information to be released:

__Complete Health Record **__ History and Physical Exam __ Labs __ Imaging reports**
__ Billing records __ Consultation reports

Specifically, I authorize the information source to release my medical or billing records containing information in reference to: (PLEASE *INITIAL*)

Drug and alcohol abuse _____ Mental Health/Psychiatric treatment _____ HIV/AIDS _____

I understand that I may revoke this authorization at any time by submitting a request in writing to Alamo Family Practice. Unless revoked, the authorization will expire 180 days from the date of signature.

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied solely for the reason of not signing this form. I can inspect or copy the protected health information to be used or disclosed.

I understand that by providing the correct information for the group releasing the information, Alamo Family Practice will fax this release to the number provided. However, it is my responsibility to check on the status of records received. If Alamo Family Practice is unable to receive the information, either due to incorrect information provided or failure of the entity releasing information to correctly transmit the records, it will be my responsibility to obtain the records.

I authorize the information source to release the protected health information specified above.

Signature: _____ Date: _____

Authority to sign if not patient _____ Relationship to patient _____

Identity of requestor verified via Photo ID by _____