

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as HIV, AIDS, mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

Print Patient Name _____ Date of Birth _____ Social Security Number _____

Date(s) of service: _____

Purpose of the use and/or disclosure: _____

NOTE: Medical Practices Act 159.005 states that consent for release of information is not valid if it does not give specific reasons or purposes for the release of information.

I hereby authorize you to release to: **South Texas Orthopedic and Spinal Surgery Associates**
9150 Huebner Road, Suite 350
San Antonio, Texas 78240
Phone #: (210) 561-7234 Fax #: (210) 561-7240

DESCRIPTION OF INFORMATION TO BE RELEASED

Please mark the materials to be released pursuant to this authorization:

- | | | |
|---|--|--|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Records | <input type="checkbox"/> X-ray/Radiology Films |
| <input type="checkbox"/> Diagnostic Studies | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Billing Records | <input type="checkbox"/> Other: _____ |

This authorization includes the release of documents in your possession whether or not created in your office or by another healthcare provider.

I understand authorization for the use or disclosure of the information identified above is voluntary, and I need not sign this form to ensure healthcare treatment. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form.

I understand that the information released in response to this authorization is subject to disclosure to other parties, and that any other person, firm, or entity that releases material pursuant to this authorization is released from any liability that might otherwise result from the release of this information.

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until: _____.

I further understand that I may revoke this authorization at any time by notifying this office in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of patient or representative _____ Date _____

If you are not the patient but are executing this authorization as a legal representative or other person authorized to act for the individual named above, please complete the following information:

Printed name of Representative _____ Relationship to the patient _____

Describe the representative's authority to act for the patient and attach supporting documentation: _____
