

Medical Records Release Form

In accordance with state law and regulatory agency requirements, the health record is the property of **PROCARE INTERNAL MEDICINE ASSOCIATES**. By signing this form, I authorize you 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 result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

I hereby authorize the release of information

Patient: _____

DOB: _____ SSN: _____

Address: _____

City/State/Zip: _____

FROM:

TO:

Physician Name: _____

ProCare Internal Medicine Associates

Office Name: _____

11212 State Hwy 151, Plaza I, Ste 220

Address: _____

San Antonio, Texas 78251

City/State/Zip: _____

210.509.7462 phone

Phone #: _____

210.509.7464 fax

Fax #: _____

Information to be released

_____ Complete medical record

_____ Items as indicated below

_____ Progress Notes

_____ Problem List

_____ Consultations

_____ Lab Reports

_____ X-ray Reports

_____ Immunizations

_____ Medication List

_____ H&P

_____ Mental Health Records

_____ Other (specify: _____)

Patient, guardian or legal representative

Date

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.