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: _____	10823 Town Center Drive
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.