

PMA Clinical Research, PLLC

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I hereby request and authorize _____

To release copies of my records to: PMA Clinical Research, PLLC
4410 Medical Drive, Suite 100
San Antonio, Texas 78229
Office number: (210) 614-4000 Fax: (210) 614-9114

This authorization to all the reports checked:

<input type="checkbox"/> Admission Face Sheet	<input type="checkbox"/> Problem List	<input type="checkbox"/> Laboratory Results
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Physicians Orders	<input type="checkbox"/> X-Ray Reports
<input type="checkbox"/> EKG	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Colonoscopy Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Endoscopy Reports
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Other: _____

Purpose of Disclosure:

Medical Care _____ Insurance _____ Attorney _____ Other _____

TO THE PARTY RECEIVING INFORMATION: This information has been disclosed to you from the records whose confidentiality is protected by Federal Law. Federal Regulation (42CR, Part 2) prohibits you from making further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of medical information is not sufficient for this purpose.

I understand the records to be furnished or reviewed include information concerning my case history, examinations and treatment, including but not limited to and all information related to HIV testing, diagnosis, and treatment of testing for acquired immune deficiency syndrome (AIDS) or related disorders, if any. I understand this information may include reference to psychiatric treatment or testing and evaluation or treatment for substance abuse. The health care facility, employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signature of Patient

Printed Name of Patient

Date

Signature of Witness

Social Security Number of Patient

Patient's DOB