PASTEUR MEDICAL ASSOCIATES, P. A.
INTERNAL MEDICINE
4410 Medical Drive, SUITE 100
SAN ANTONIO, TEXAS 78229
210-614-4000 FAX 210-616-0449

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use of disclosure of information from the medical record of:
Patient Name _____ Account # _____
Date of Birth _____ Social Security # _____

I authorize the following individual or organization to disclose the above named individual's health information:
_____ Address: _____
This information may be disclosed TO and used by the following individual or organization:
_____ Address: _____
For the purpose of: _____
Please release the following:

_____ Problem List	_____ X-Ray/Imaging Reports-from (date) _____ to _____
_____ Progress Notes	_____ X-Ray Films
_____ History /Physical Exam	_____ Laboratory Results-from (date) _____ to _____
_____ Medication List	_____ EKG Reports
_____ Immunization Record	_____ List of Allergies

_____ Other Diagnostic Reports (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
_____ **Yes,** I consent to the release of this information _____ **NO,** I do not consent

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Anna Talamantes.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold **Pasteur Medical Associates, P.A.** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date request completed _____ #Pages copied _____ Reviewed only _____
Charges $ _____ Cash _____ Check # _____ Initials _____