

Gastroenterology Consultants of South Texas

Medical Records Release Form

Patient's Name: _____ Date of Birth: _____

I hereby authorize Gastroenterology Consultants of South Texas, PLLC to release medical records, including AIDS/HIV test results, diagnosis, treatment and related information to:

Doctor/Facility Name: _____

Fax: _____

Phone: _____

Medical Information to be disclosed and or photocopied include:

History & Physical

Diagnostic Results

Discharge Summary

Consultations

Laboratory & Radiology Results

All Dictation

Other: _____

1. If my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, the records cannot be disclosed without my written consent unless otherwise provided for in the regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict ant use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
2. With respect to any mental health information which may be contained in the medical records, I hereby waive my/his/her right to the privilages of confidentiality.
3. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

The reasons or purposes for this release of information are as follows: **Continuity of Medical Care.**

Limitations on the information you may release subject to this Release Form are as follows:

Patient Signature (Parent/Guardian/Legal Representative)

Date

[Type here]

Office (956) 365-4400

Fax (956) 365-4111