Authorization for Use or Disclosure of Information

I hereby request and authorize the office of Dennis Dilley, MD/Christopher Calabria, MD/ Phillip McAllister, PA-C located at 7835 IH 10 West, San Antonio, Texas 78230 to release copies of my medical records to:
Provider Name: Clinic Name: Phone Number: ( )

This authorization applies to all of the reports checked:

- ❑ **Complete Chart**
- ❑ History and Physical Examination
- ❑ Progress Notes and Care Plans
- ❑ Pulmonary Function Test(s)
- ❑ X-Ray reports
- ❑ Laboratory Reports
- ❑ Allergy Testing and Treatment Plans
- ❑ Other _____

Purpose of Disclosure: (Check all that apply)

❑ Medical Care ❑ Attorney ❑ Insurance ❑ Transfer Records ❑ Other _____

This authorization is valid for 90 days from the date of your signature below.

Prohibition of Re-disclosure

Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending notification to :
Darlene Dilley
7835 IH 10 West
San Antonio, Texas 78230

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ _____
Signature of Patient or personal Representative Date

_____ ___/____/_____
Name or Patient or Personal Representative Patients Date of Birth

_____
Description of Personal Representative's Authority