Request for Release and Disclosure of Patient Information

I hereby request and authorize the office of: Provider Name:_____Phone (____)_____
To release copies of my medical records to :

Dennis Dilley, MD, Christopher Calabria, M.D. and Phillip McAllister, PA-C
7835 IH 10 West, San Antonio, Texas 78230 614-4405/Fax: 614-7892

This authorization applies to all of the reports checked below:

- ❑ **Complete Chart**
- ❑ X-Ray Reports
- ❑ History and Physical Examination
- ❑ Laboratory Reports
- ❑ Progress Notes and Care Plans
- ❑ Other_____

Purpose of Disclosure: (Check all that apply)

❑ Medical Care ❑ Transfer Records ❑ Other _____

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

I authorize the release of paper copies of my/the patients' medical records.

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 HIPAA Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written 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.)

_____ _____
Signature of Patient or Personal Representative Date

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

_____

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Description of Personal Representative's Authority