Westover Hills Primary Care
9022 Culebra Rd., Suite 112
San Antonio, TX 78251

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. Please RELEASE my medical information to:

_____

Name of Physician, Hospital, or Self Phone# Fax#

_____

Address City State Zip

2. Patient Information:

_____

Print Patient Name Date of Birth Phone#

_____

Address City State Zip

3. Purpose for Records Request:

_____ (i.e. Personal use, primary care physician, transferring care, insurance change, for insurance purposes, 2nd opinion, referral)

4. Please specify records to be disclosed by checking the appropriate box ***:

- Most Recent Visit Notes
- Most Recent Labs ONLY *****Include HIV/AIDS and Sexual Transmitted Disease Info** *** Yes No
- Most Recent Imaging
- All Records *****Include HIV/AIDS and Sexual Transmitted Disease Info***** Yes No

5. Please note* Please allow 10 business days for your request to be processed.**

I understand that the authorization for disclosure of records as detailed above, unless specifically limited by me in writing, will extend to all aspects of treatment provided. These records may include testing for all sexual transmitted diseases, AIDS, and hepatitis, as well as drug, alcohol and/or psychiatric information. Westover Hills Primary Care is hereby released from all legal responsibility of liability for the release of the above disclosure of information. I have the right to withdraw this authorization at any time and that such revocation must be in writing.

Print Name: _____ Signature:_____ Date_____

Staff Use Only:

Completed by:	Reviewed:	Fax	Mail	Picked up