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

Medical Records Release Authorization

I, ____ , ____________________
Patient Name Date of Birth

authorize ____ to disclose information from my health records.
Previous Office

Phone:__________________________________ Fax:_____________________________________

2. The information is to be disclosed to: **Westover Hills Primary Care**
Contact Person: Fabiola Mejia
Attn: Medical Records
Phone/Fax: 210-802-3777/ 210-819-4555

I authorize this information to be disclosed in the following ways:

- ☐ Written/Photocopy/Paper
- ☐ Verbal
- ☐ Fax
- ☐ Electronic Mail

Purpose of the disclosure: Medical Record Transfer to a PCP

Specific reports to be disclosed: Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)

I give specific authorization to disclose the following information:

- ☐ HIV test results
- ☐ Documentation of AIDS diagnosis
- ☐ Drug and alcohol abuse treatment records
- ☐ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

____ ___________________________
Signature of Patient or Representative Date

____ ____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient
Relationship to Patient

Phone: 210-802-3777 Fax: 210-819-4555
info@WestoverHillsPrimaryCare.com www.WestoverHillsPrimaryCare.com