North San Antonio Healthcare Associates
3338 Oakwell Court, Suite 107
San Antonio, Texas 78218-3087
(210) 822-3646
FAX (210) 822-5242

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION TO RELATIVE / FRIEND / CAREGIVER

Patient's Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Alternate Telephone: _____

SSN: _____ Previous/Maiden Name: _____

I Request and Authorize: **NORTH SAN ANTONIO HEALTHCARE ASSOCIATES**
Dr. _____
3338 Oakwell Court, Suite 107
San Antonio, Texas 78218-3019

To release any and all medical information pertaining to my healthcare to:

Name: _____

Relationship: _____

This request and authorization applies to:

_____ All health care information

_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and / or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders / mental health, or drug and / or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders / mental health, or drug and / or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____
Relationship or status if signed by anyone other than the patient
(Parent, legal guardian, person representative, etc.)

THIS AUTHORIZATION REMAINS IN AFFECT UNTIL WRITTEN NOTICE REVOKING THIS AUTHORIZATION IS RECEIVED BY OUR OFFICE.