4383 Medical Drive
San Antonio, TX 78229
P: (210) 593-5700
F (210) 593-5870 Medical Records

Authorization to Disclose Health Information for Continuity of Care & Release of Medical Records

Patient Name: _____**Date of Birth:** _____

I authorize the use or disclosure of the above-named individual's health information.
The following individual or organization is authorized to make the disclosure:

_____
(Name of Organization)

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

All medical information may be disclosed to and used by the following individual or organization:

_____
(Name and Address of Physicians or Clinic)

_____
(Name and Address of Family and Friends)

For the purpose of: _____
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been used or released in reliance upon this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that if I refuse to sign this authorization, STOH cannot refuse to provide, or condition the provision of treatment to me. I understand that I may inspect or obtain a copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.If I have questions about disclosure of my health information,I can contact the STOH Dir. of Health Information Management at 593-2651. I understand that I will receive a copy of this authorization upon my written request to STOH.

_____ _____ _____
Signature of Patient or Legal Representative *Date* *Relationship to Patient*

_____*Witness*