Tandi Medical Center

Authorization for: __Disclosure __Inspection __Amendment Of Protected Health Information

Patient Name ______________________ ***Date of Birth*** ____-____-____ ***Social Security #*** ________-______-__________

Address: ______________________________ Telephone#: ________________

To release information ***from*** the medical records of: **Dr.** ______________________________

Address ____

Phone: ______________________ **Fax#:** ______________________

***To*: Tandi Medical Center Fax #: (210) 999-5605- Phone #: (210) 999-5586**

For treatment dates: ______________________ (Specific Dates-This **MUST** be Completed)

For the following purpose: __Medical Care __Legal __Insurance __Other (detail below)

__ Abstract Pertinent Information
__Lab
__Emergency Room
__Imaging/Radiology
__Nursing Notes
__H & P
__Cardiac Studies
__MD Progress Notes
__MD Orders
__Face Sheet
__Operative/Procedure Report

___Entire Record **EXCLUDING**-HIV Testing & Chemical Dependency
___Entire Record **INCLUDING**- HIV Testing & Chemical Dependency
___ Entire Record **INCLUDING**-HIV Testing **ONLY**
___ Entire Record **INCLUDING**-Chemical Dependency **ONLY**
___ Itemized Bill
Other ______________________________

This authorization is valid until the 180thday after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above. I, the undersigned, have read the above and authorize the staff of Dr. ______________________ to disclose such information as herein contained ***to*** Tandi Medical Center. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

Date: ________ Signature of Patient/Guardian: ______________________ Relationship: __________

Fees/Charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.