Donna Medical Clinic • Elsa Medical Clinic • Donna Day & Night Clinic

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

Patient Name (Print Name) _____DOB_____

Address/City/State/Zip: _____

Social Security #_____ (optional)
Daytime Phone:_____(optional)

Release From:
_____
_____
_____
Please Release the Following:

Send To: Donna Day & Night Clinic

2010 E. Business 83, Donna, TX, 78537
T: (956) 461-6666
F: (956) 461-6670

_____ Problem List	_____ X-Ray Reports	_____ Complete Medical Records
_____ Progress Notes	_____ X-Ray Films	_____ Medication List
_____ History/Physical Exam	_____ EKG Reports	_____ Billing Records
_____ Lab Reports	_____ Other Diagnostic Reports	_____ Alcohol & drug treatment
_____ Immunizations	_____ (Specify)	_____ Mental Behavioral
	_____ Other (Specify)	_____ Human immunodeficiency virus (HIV)

Dates of Service: From_____ **To**_____

Purpose or Need for Disclosure:

____Continued Patient Care ____Personal Use _____Attorney/Legal ____Disability Determination
____Insurance Claim/ Application Other (Specify) _____

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS IN ACCORDANCE WITH THE SPECIFICATIONS LISTED ABOVE. I understand the information used or disclosed may include information relating to Acquired immunodeficiency Syndrome (AIDS). Human immunodeficiency Virus (HIV), sexually transmitted diseases, behavioral or mental health services, and/or treatment for alcohol and drug abuse. Any other use of this information without the written consent of the patient is prohibited. I further understand that this authorization shall be valid for 90 days unless otherwise stated below or revoked through written notice to the medical records department (address as above) except to the extent that **Donna Day & Night Clinic** has already used or disclosed information under the authorization. I understand that **Donna Day & Night Clinic** takes no responsibility for the safe arrival of medical records and/or x-rays that are taken by the patient. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected. **Donna Day & Night Clinic** reserves the right to charge for the copying of medical records as permitted by law.

_____ _____
SIGNATURE of Patient, or Legal Guardian **Date**

Person authorized by the patient means the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives deceased patient, an adult member of the deceased patient's immediate family may qualify. A court appointed temporary guardian may also qualify to consent to the release of records.

Relationship to Patient:
Patient is: Minor Incompetent Disabled Deceased
Legal Authority:
Legal Guardian Next of Kin