



**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: Elsa Medical Clinic**

P.O. Box 356  
Elsa, TX. 78543

T: (956) 262-1304  
F: (956) 262-3929

<input type="checkbox"/> Problem List <input type="checkbox"/> Progress Notes <input type="checkbox"/> History/Physical Exam <input type="checkbox"/> Lab Reports <input type="checkbox"/> Immunizations	<input type="checkbox"/> X-Ray Reports <input type="checkbox"/> X-Ray Films <input type="checkbox"/> EKG Reports <input type="checkbox"/> Other Diagnostic Reports _____ (Specify) <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Complete Medical Records <input type="checkbox"/> Medication List <input type="checkbox"/> Billing Records <input type="checkbox"/> Alcohol & drug treatment <input type="checkbox"/> Mental Behavioral <input type="checkbox"/> Human immunodeficiency virus (HIV)
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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 **Elsa Medical Clinic** has already used or disclosed information under the authorization. I understand that **Elsa Medical 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. **Elsa Medical 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

Donna Medical Clinic: 307 North D. Salinas Blvd. Donna, TX 78537 • Ph: (956) 464-2402 • Fax: (956) 464-3339

Elsa Medical Clinic: 101 S. Broadway Elsa, TX 78543 • Ph: (956) 262-1304 • Fax: (956) 262-3929

Donna Day & Night Clinic: 2010 E. Hwy Business 83 Donna, TX 78537 • Ph: (956) 461-6666 • Fax: (956) 461-6670