Office Information:
5534 Rogers Road
San Antonio, Texas 78251
P: (210) 684 -1000
F: (210) 684 - 1003

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to RIVERCITY WOMEN'S HEALTH, PLLC and affiliated healthcare providers.

Disclosing Physician / Practice: _____ Phone: (_____) _____-_____

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Ultrasound
_____ Chest X-Rays
_____ CT Scan
_____ Echocardiograms
_____ M.R.I.
_____ E.K.G.
_____ Office Notes
_____ Labs Reports / Tests

Protected Health Information to be disclosed to:

RIVERCITY WOMENS HEALTH PLLC
Attn: MEDICAL RECORDS
5534 ROGERS ROAD
SAN ANTONIO, TX 78251
PHONE: (210) 684 - 1000

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to RiverCity Women's Health, PLLC.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). RiverCity Women's Health, PLLC will not condition treatment or payment based upon my signing of this Authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by RiverCity Women's Health, PLLC. and no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature | Date | Name (if other than Patient)