



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

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	_____ Change of Doctor
_____ Referral to Specialist	_____ 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)