RGV Adult & Geriatric Medicine Specialists

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_____ has recently become my patient. I would appreciate it very much if you would send me the medical history and any information you think may be useful to me. If you have any questions concerning this request, please contact my office**.** A signed consent form is on this page for the purpose of continuation of medical care.

I hereby authorize:

Doctor/Facility name:_____

Phone: _____ Fax:_____

Social Security #:_____

To release information to:

RGV ADULT AND GERIATRIC MEDICINE SPECIALISTS, P.A.

RECORDS AUTHORIZED TO BE RELEASED:

__Office visit notes	**__Discharge summary**	**__Any and All**
__Laboratory results	**__Recent admission history and physical**	**__Mental health records**
__Radiology reports	**__Complete hospital chart**	**___Other_____**
	Date of Service: _____	

I, the undersigned, have read the above and authorized the staff of RGV Adult & Geriatric Medicine to request my medical records, including any mental health records. I understand that this content may be withdrawn by me, in writing at any time except to the extent that action has been taken in reliance upon it. I understand the re-disclosure of this information to a party other than the designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold that facility harmless, for complying with this "Authorization for Release of Medical Information."

Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.

This authorization expires one year from the date signed below and covers only the specific records requested above.

Date: _____

Patient Name: _____DOB: _____

Representative Printed Name: _____

_____

Patient or Representative Signature

_____

Witness Signature