M E D I C A L R E L E A S E O F I N F O R M A T I O N

Jorge A. Saravia, MD
2829 Babcock Rd., Ste. 436
San Antonio, TX 78229
Voice (210) 614-3657
Fax (210) 614-3659

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROCTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

If this authorization is for psychotherapy notes, it may not authorize the use of disclosure of any other type of protected health information.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information in Section 2 below. I give this authorization voluntarily.

Patient's Name: _____ Date of Birth: _____

Address: _____ City/Zip Code: _____

Telephone Number: _____ Social Security Number: _____

2. AUTHORIZATION TO RELEASE AND/OR REQUEST RECORDS

- ☐ All Medical Records or _____

Releasing the protected health information: (please include as much information as possible)

- ☐ Dr. Jorge A. Saravia or _____

Receiving the protected health information: (please include as much information as possible)

- ☐ Dr. Jorge A. Saravia or _____

3. Ending date of Authorization: Select on of the following choices:

- ☐ Ending date: _____ Other: _____

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice to revoke this authorization. In addition, I understand that I am giving this authorization as a condition and I revoke the authorization, the insurance company has a right to consent my claims under the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information or research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization of my treatment if provided solely for the purpose of creating protected health information for disclosure to a third party. An under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. INDIVIDUAL PATIENT'S SIGNATURE

I have had a chance to read and think about the content of this authorization form and I agree with all statements made in this authorization, I understand that, by signing this form, I am confirming my authorization to release and/or request the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____

Print Name: _____

Date: _____

Relationship: _____

You have a right to a copy of this form after signing it