Patient Authorization for Release of Health Records

I authorize _____to disclose information from the health records of:

Patient Name Telephone#

Patient Address

MRN# Date of Birth Social Sec.#

The information is to be disclosed to: Surgical Oncology Associates of South Texas - Dr. Morton Kahlenberg
Address: 8715 Village Drive, Suite 620 San Antonio, Texas 78217 Phone: 210-946-1400 Fax 210-946-1010

I authorize this information to be disclosed in the following ways:
_____ Written / Photo Copy _____Verbal _____ Fax _____ Electronic Email _____ Standard mail
_____ Delivery - Overnight/Express

Purpose of disclosure is for clinical and surgical evaluation.
Dates of treatment: From _____ To _____

Specific reports fo be disclosed:
[ ] progress notes [ ]Lab reports [ ]operative reports [ ]discharge summary [ ]radiology reports [ ]consultation reports[]other images photographs / video tapes [] records from other facilities
[ ]entire health record (including but not limited to, information regarding medical / health treatment, insurance, demographics, referral documents, and records from other facilites)
Other (please specify)_____

I give specific auhorization to disclose the following information:
[ ]HIV test results [ ]documentation and alcohol abuse treatment records [ ] documentation of AIDS diagnosis
[ ] psychiatric / mental health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying _____ in writing.

My treatement will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Fedceral or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____.

I release the individual or organization named in this authorization from legal responsibilitiy or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authoirization, if requested. A photo copy of this authorization is valid as the original

Signature of the patient (or patient representattive) *Date*

Printed Name of patient or representatative *Authority of representative to act for patient*

Revised 9/8/08 MIS