

Authorization for Release of Medical Record Information

Name: _____ Date of Birth: _____
Address: _____ Medical Record No.: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

I hereby authorize:

Rio Grande Orthopedic Center
1601 Treasure Hills
Harlingen, TX 78550

To disclose information from my, or my minor child's medical records to (name and address):

Name #1: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Name #2: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This information is needed for the following reason:

The specific information I wish to have released is (included dates of treatment):

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a one hundred eighty (180) day period from the date it is signed.

Your Signature: (or Parent or Legal Guardian if Minor Child) Date:

Expires: _____

Witness: _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

- I DO consent to have this information disclosed.
- I DO NOT consent to have this information disclosed.

Signature: (Parent or Legal Guardian if Minor Child) Date:

This medical record may contain information concerning HIV testing and / or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

- I DO consent to have this information disclosed.
- I DO NOT consent to have this information disclosed.

Signature: (Parent or Legal Guardian if Minor Child)

Date: