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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:** _____

To release information to:

RGV DIABETES, ENDOCRINOLOGY & AMBULATORY CENTER

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 authorized the staff of RGV Diabetes, Endocrinology & Ambulatory Center 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 I understand that this content may be withdrawn by me, in writing at any time except to the extent that action has been taken in reliance upon it.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 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