ESSENTIAL
med clinic

AUTHORIZATION TO REQUEST MEDICAL RECORDS FROM ANOTHER HEALTH CARE PROVIDER/FACILITY

Patient Full Name: _____

Date of Birth: _____ **Phone:** _____

Address:_____ **City/State/zip**:_____

Above listed patient authorizes the following healthcare facility to make record disclosure(previous doctor/specialist):

Name:_____

Address:_____**City/State/Zip**:_____

Phone: (____)_____ **Fax:** (____)_____

Information regarding person or entity who can receive and use this information:

Name: _____ESSENTIAL MED CLINIC/ Dr. Freda Cobbinah_____

Address:_2810 N LOOP 1604W, SUITE 102_____City/State/Zip: **SAN ANTONIO, TX, 78248**

Phone: (210)568-7555_____ **Fax: (210)200-5136**_____

Description of the purpose of the use and/or discolosure: Continuity of Patient Care

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Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults

□ Other: _____

This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form. I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand this information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand this authorization will expire on_____or 180days from the date of this signed authorization.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____