AUTHORIZATION OF DISCLOSURE OF CONFIDENTIAL INFORMATION

(Medical Records Release Form)

This Authorizes: _____

_____

Phone: _____ Fax: _____

to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or otherwise release confidential information. I agree that a photocopy of this authorization may be considered valid.

- ❑ Complete record
- ❑ Records of care from the following dates: _____to_____
- ❑ Records concerning the following conditions:_____
- ❑ Other, Please specify:_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS/HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Patient Signature:_____Date:_____

The reasons or purpose for this release of information are as follows:

- ❑ Medical Care
- ❑ Attorney
- ❑ Specialist
- ❑ Insurance
- ❑ Changes in Medical Provider
- ❑ Other_____

Release the information to: Texas Family Physicians @ River Place
Dr. Martin C. Molina
6618 Sitio Del Rio Blvd.
Building. B, Ste. 101
Austin, Texas 78730
Phone: 512-524-2336 Fax: 512-372-8525

Patient Name(s) Date of Birth: Social Security Number:

_____
_____
_____
_____

Patient/Guardian Signature:_____ Date:_____