ADVANCED INTERNAL MEDICINE PRACTICE

AIM for better health

Authorization for Use and Disclosure of Medical Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorizations.*

Authorizations

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named healthcare provider may hold, by means of mail, fax or other electronic methods.

To: Advanced Internal Medicine Practice
1418 Walkers Way, Suite # 101
San Antonio, TX 78216
Phone #: 210- 245-7933 Fax#: 210-761-3824
Email: staff@aimprimarycare.com

The medical information/ records will be used for the following purpose: Continuation of care_____.
This authorization is:
{ } Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment)
{ } Limited to the following medical information: _____

I consent to the specific release of the following records:

Drug/Alcohol/ Substance Abuse _____(initials) HIV Diagnosis/ Treatment _____(initials)

Psychiatric/ Mental Health _____(initials) Genetic Information _____(initials)

Tests for Antibodies to HIV _____(initials)

Duration:

This authorization shall be effective immediately and remain in effect until _____(date)

Restrictions:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____
Patient Name Date

_____ _____
Patient Signature/ Patient Representative Relationship to Patient