GRACE M. SALINAS-GARCIA, M.D., P.A.
9518 TIOGA DR.
SAN ANTONIO, TEXAS 78230

TEL # (210) 495-4888 FAX # (210) 495-1333

CONSENT TO RELEASE INFORMATION

Name of Client:_____ Name of Legal Gaurdian:_____

Date of Birth:_____ Phone Number:_____

Date of Request: _____

I, hereby, authorize GRACE SALINAS-GARCIA, MD, and the following person(s) or agency to mutually exchange records and information, in their professional capacity, pertinent to my file. I understand that my medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

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Information requested:

___Complete Health Record ___Operative Report ___Psychological Testing

___Discharge Summary ___Psychological Evaluation ___Lab, X-ray, Pathology

___Progress Notes ___History/Physical

___Other_____

I, hereby, certify that I am the above-named client (or legal guardian of the client)

I understand this consent may be revoked by me (in writing) at any time and will automatically expire in 180 days. This is in compliance with the State of Texas Health and Safety Code.

Please initial: Client_____or Legal Gaurdian_____

Signature:_____ Witness_____

Address:_____ Today's Date:_____

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