Heart and Vascular Clinic of San Antonio

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

WILLIAM C.L. WU, MD, MPH, FACC, FSCAL, FSVM

Patient's Full Name: _____

Address: _____ **City**: _____ **State**: _____

Date of Birth: _____ **Social Security No**: _____ / _____/ _____

Authorizes Heart and Vascular Clinic of San Antonio to release/obtain the following medical information:

NAME OF PERSON/FACILITY: _____

PHONE NUMBER:_____ FAX Number: _____

ADDRESS: _____ state _____ ZIP:_____

Check all that may be released:

☐ History	☐ Physical	☐ Progress Notes	☐ Lab Report
☐ Operative Report	☐ X -Ray	☐ Care Plan	☐ EKG Report
☐ Therapy Report	☐ Other (Please Specify)		

This Authorization covers patient care from _____ to _____

Purpose of disclosures:

_____ **Medical Care** _____ **Attorney** _____ **Insurance** _____ **Other** _____

This authorization shall be valid for one year from the date of signature. The patient may revoke this authorization in writing at any time prior to the expiration date. File copy is considered equivalent to the original.

I understand that:

1. I may refuse to sign this authorization.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditional upon on signing this authorization.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient's Representative:	Date:
Print Name of Patient/Guardian/Patient's Representative:	Relationship to Patient

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