Surgical Consultants of San Antonio
Dana L. Reiss, M.D.
9150 Huebner Road, Suite 250
San Antonio, TX 78240
Office: 210.614.9210 / Fax: 210.614.6859

I hereby authorize the use or disclosure of information from the medical records of:

Patient Name: _____

Date of Birth: _____

I authorize the following individual or organization:

_____

To release to: Dana L. Reiss M.D.

For the purposes of: Medical Care

Please release the following:

____ History/Physical Exam
____ Radiology Reports
____ Laboratory Results
____ Other (Specify) _____

____ Progress Notes
____ **All of the above**

_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, 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.

___**Yes**, I consent to the release of this type of information.

___ **No**, I do not consent to the release of this type information.

_____

This authorization shall remain in effect for 1 year from the date signed or until: _____

I understand that:

I may inspect or copy the protected health information to be used/disclosed.
I may revoke this authorization at any time, in writing.
Information used/disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.

X _____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient (*If Legal Representative*)