Frank Rubalcava, M.D. **Ted Trusevich, M.D.** **Yasser Farra, D.O.**
Charles Bailey, M.D. **Sheri Boyd, M.D.**
Prasantha Bathini M.D. **Ronnie Garcia, M.D.**
Melanie Morris, R.N., FNP-BC

Patient Name: _____ Date of Birth _____

Social Security # _____ Phone: (H) _____(W) _____

Records to be requested from: Facility / Physician _____

Phone / Fax_____

To release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

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

Initial: _____ Date:_____

Mental health/Substance Abuse: I consent to the release of my medical records related to treatment for mental health and /or substance abuse with the rest of my medical records.

Initial: _____ Date: _____

We are requesting the following records: _____

Release my protected health information to: New Braunfels Cardiology
1626 E. Common
New Braunfels, TX 78130

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

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice: Darla Wright

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to context a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____

Signature of Patient or Personal Representative