CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

Patient Authorization / Restriction for Release of Medical Records

IF YOU WOULD LIKE TO RESTRICT OR AUTHORIZE METRO HEALTH TO RELEASE YOUR PHI, YOU MUST COMPLETE THIS FORM. By law, an individual has the right to inspect and obtain a copy of his or her own Protected Health Information (PHI). An individual also has the right to allow for or restrict the release of their PHI to other individuals or entities in writing. By completing this form, you are authorizing or restricting the San Antonio Metropolitan Health District (Metro Health) from releasing your PHI to those indicated below. Please note any restrictions may be denied and this form must be filled out in its entirety in order for the form to be accepted. If you need assistance in completing this form, please notify the Metro Health staff.

Section A: Patient (or minor child) information - Individual whose PHI is being authorized or restricted for release

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth (MM/DD/YYYY): _____ Telephone #: _____

Section B: Please specify the records you would like to have released or restricted by listing it in the space below. If you would like only the specific dates of the records released / restricted, you must indicate the dates for each type of record. (Example: Immunization Records, Entire Medical Record, Lab Results, etc)

☐ **Immediate Release** (Specified records will be sent to the named individuals; authorization expires upon completion of the listed disclosure)

☐ **Future Release** (Specified records will be released ONLY when requested by the named individuals on this form; authorization expires 3 years from date signed or when minor turns 18)

☐ Immunizations Record ☐ Lab Results ☐ Radiology Results

☐ Other Specified:

Specific Authorization Required: ☐ STD Records ☐ HIV Records ☐ Substance Abuse Services Referrals Dates Requested:

Section C: Please select who you would like to restrict or authorize the release of your PHI to. You must provide the contact information for those indicated below and all names must be the full legal names of individuals or clinics. Please check one of the boxes below.

☐ I authorize the release my PHI (as specified in section B) to the designated individuals listed below.
☐ I restrict Metro Health from releasing my PHI (as specified in section B) to the individuals listed below.

Date of Expiration:

Name: _____ Relationship to Patient: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone #: _____ Fax #: _____

Name: _____ Relationship to Patient: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone #: _____ Fax #: _____

Name: _____ Relationship to Patient: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone #: _____ Fax #: _____

Skip sections D – E if you are restricting access to PHI

Section D – Format of PHI to be released: Please check all format options that are approved to be used by Metro Health. You must check at least one option.

☐ **Paper Copy** ☐ **Electronic Copy** (Note: If the PHI is not stored in an electronic format, it will be released by paper copy.)

☐ **E-Mail** (I understand E-Mail is UNSECURE and I accept the risks associated with this form of disclosure.) **E-Mail:**

Section E: Please indicate the purpose for the release of the specified PHI below.

☐ Own Personal Records ☐ To pick up a copy on my behalf. ☐ Continued Care ☐ Other:

Privacy Notification: With few exceptions, you have the right to request and to be informed about information that Metro Health collects about you. You have a right to review and obtain a copy of the information, in addition, to requesting Metro Health to correct any information determined to be incorrect. You may view a copy of the HIPAA Privacy Notification at http://www.sanantonio.gov/Health/AboutUs/ClinicLocations/HIPAANotice.aspx or obtain a copy from any Metro Health clinic.

By signing below, I authorize the release of the designated information and understand the information may be subject to re-disclosure by the recipient. I understand I may revoke this authorization in writing at any time except to the extent that action has already been taken. I have been given a copy of the HIPAA Privacy Notification for my review and all of my questions have been answered to my satisfaction. I understand my eligibility for enrollment, treatment, payment, or services will not change if I refuse to sign this form. I recognize this authorization is completely voluntary. I understand this authorization will expire 3 years from the date signed below, unless I have listed an expiration date in section C. In the event the patient is a minor, this expiration will expire when the minor turns 18 years old, whichever date comes first.

Section F: If you are a Parent/Legal Guardian of a Minor, or Legally Authorized Representative of the patient listed above, please complete this section below. IMPORTANT: Please attach any legal documents to show proof of legal guardianship or authorized representation of the patient if they are not already on file.

Full Name:		**Relationship to Patient:**			
Address:			**City:**		
State:		**Zip Code:**		**Telephone #:**	
Signature (X)			**Date**		

For Notary Use Only (If Applicable)

State of Texas
County of _____

(Personalized Seal)

This instrument was acknowledged before me on _____ by _____
Date **Name(s) of person(s) acknowledging**

_____
Notary Public's Signature

Patient Authorization / Restriction for Release of Medical Records

For Metro Health Use ONLY				
Authorization for Immediate Release:				
Method of Authorization Submission	**Method of Records Release**	**Authorized Personnel Name (Print)**	**Authorized Personnel Signature**	**Date**

Revocation of Authorization:

At the request of the patient or their Legally Authorized Representative, this authorization may be revoked at any time in writing. This section must be completed by the Metro Health employee receiving a request for revocation of this authorization.

Name of Patient/Legally Authorized Representative		**Date of Request**	
Reason for Revocation			
Method of Identification (include ID #s if applicable)			
Employee Name		**Date**	
Division		**Method of Request**	

Comments:

Please include any written requests for revocation of this authorization with this form for reference.