CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

Request for Disclosure of Medical Records

IF YOU WOULD LIKE TO OBTAIN A COPY OF PHI, YOU MUST COMPLETE THIS FORM. By law, an individual has the right to inspect and obtain a copy of his/her own Protected Health Information (PHI). An individual has the right to request his/her PHI to be released to other individuals or entities with specific authorization. By completing this form, you are submitting a written request for access to the PHI of the designated individual. PHI will only be released to persons authorized by the patient or his/her legal representative and only in the formats approved by the patient or his/her legal representative. This form must be filled out in its entirety to be accepted. If you need assistance in completing this form, please contact the San Antonio Metropolitan Health District (Metro Health) staff.

Section A: Patient information (Individual whose PHI is being requested)

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

☐ Immunization Record ☐ Lab Results ☐ Specific Dates: ____
☐ Complete Medical Record ☐ Radiology Results
☐ Other Specified:

Format of PHI Requested:

Paper Copy: ☐ Mail ☐ Other Specified:
☐ In Person ☐ Fax #:( ) ____ E-Mail: ____

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

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

Section D: If you are not the patient named in section A, please complete this section below. If you are a Parent/Legal Guardian of a Minor, or Legally Authorized Representative of the patient listed above, 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 #:**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that Metro Health collects about you. Metro Health reserves the right to deny any requests for access to PHI as deemed necessary or restricted by law. It is Metro Health's goal to safeguard all PHI and ensure the confidentiality and privacy of all patients and clients. You may view a copy of Metro Health's **Notice of Privacy Practices (NPP)** at http://www.sanantonio.gov/health. Physical copies of the NPP are available any Metro Health Clinic or office for your records.

By submitting this form, I am requesting the release of the designated information to myself and understand it is my responsibility to safeguard the information once it is disclosed to me. I understand that if I am not the patient or patient's Legally Authorized Representative, I may only access this information if there is a written authorization on file from either the patient or Legally Authorized Representative prior to the release of information. I understand it is against the law to falsify my identity or any other information to obtain access to an individual's PHI. I attest that all information included on this form is accurate and I am authorized to view/receive the indicated PHI.

For Notary Use Only

State of ____________
County of ____________

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

(Personalized Seal)

____
Notary Public's Signature

Signature (X)	**Date:**

Metro Health Staff Use Only

Method of Request	Method of Record Release	Authorized Personnel Name (Print)	Authorized Personnel Signature	Date