Samuel N. Landero, MD
Board Certified in Family Medicine
Board Certified in Obesity Medicine

Authorization for Release of Medical Information (Outgoing)

I hereby authorize Arroyo Vista Family Medicine to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as human immunodeficiency virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), behavioral and mental health, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary.

____
Patient Name   Date of Birth   Social Security Number

Date(s) of service (if known):____

I authorize the release of the following:

☐ Last ______ Progress Notes
☐ History/Physical Exam
☐ Lab Reports
☐ Diagnostic/X-Ray
☐ Immunization Records
☐ Other ____

Including Information (if applicable) pertaining to: ☐ Mental Health ☐ Drug /Alcohol ☐ HIV/AIDS

Purpose or need for disclosure:

☐ Continued Patient Care
☐ Attorney/Legal
☐ Disability Determination
☐ Personal Use
☐ Insurance Claim/Application
☐ Other (specify): ______________________________________

____
Name of person to whom records are to be disclosed   Phone number   Address (including City, State, Zip)

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or healthcare provider, the released information may be subject to re-disclosure and no longer be protected by federal and state privacy regulations. The facility, its employees, officers, and physicians are hereby released of any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until ___________ (if prior to 180 days from date signed).

I further understand that I may revoke this authorization at any time by notifying the Office Manager, Sheena García, in writing, at Arroyo Vista Family Medicine, 1821 S. Sesame Square, Suite #2, Harlingen, TX 78550. I also understand that the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken prior to receipt of the written revocation.

X____
Signature of Patient or Patient’s Legal Representative   Relationship to Patient   Date

- FOR OFFICE USE ONLY -

Record of Disclosure:

Date of Disclosure: ____________________ PHI Disclosed:____________________________ Purpose: ________________________

Person to Whom Disclosed: Name/Firm/Address: ____

Person Making Disclosure: ____ Title: ___________________________