ARROYO VISTA
FAMILY MEDICINE

Samuel N. Landero, MD
Elieth Jaramillo, PA-C
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Authorization for Release of Medical Information (Incoming)

I hereby authorize the release of information from the medical record of:

_____

Patient Name Date of Birth

Information Released To:

Arroyo Vista Family Medicine
1206 South F Street, Suite 1
Harlingen, TX 78550
Phone: (956) 412-2836
Fax: (956) 412-2837

From:

_____

_____

_____

Please Release the Following:

- ☐ Last_____Progress Notes
- ☐ History/Physical Exam
- ☐ Lab Reports

For Dates: _____

- ☐ Diagnostic/X-Ray
- ☐ Immunization Records
- ☐ Other _____

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

Purpose or Need for Disclosure:_____

_____

_____

I understand the following (See CFR§ 164.508(c)(2)(i-iii)):

a. This authorization is voluntary and I can refuse to release some or all of my records. However, I understand such refusals may result in improper diagnosis, improper treatment, and/or have other negative consequences.
b. Arroyo Vista Family Medicine cannot control people or organizations receiving this information to prevent re-release of it without my approval.
c. I have the right to revoke this authorization in writing any time by notifying Arroyo Vista Family Medicine at 1206 South F Street, Suite 1, Harlingen, TX 78550. However, stopping this Release of Information will not affect any information released prior to revoking my authorization for release.

X _____

Signature of Patient or Patient's Legal Representative Relationship to Patient or Legal Authority

_____

Witness Date