SOUTH TEXAS RADIOLOGY IMAGING CENTERS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please contact Medical Records at (210) 617-9729 with questions.
Completed forms can be faxed to (210) 617-9021.

Patient Information

Patient Name: _____

Date of Birth: _____ Last Four Digits of SSN: _____

Address: _____

Phone Number: _____ Name of Parent/Legal Guardian (if applicable): _____

Medical information to be released:

Exam Type	Date(s) of Service	Exam Type	Date(s) of Service
☐ X-Rays/Fluoroscopy		☐ Mammograms	
☐ Ultrasound Scans		☐ CT Scans	
☐ MRI Scans		☐ Nuclear Medicine/PET Scans	
☐ Other (specify)			

Who is requesting release of medical information?
☐ Patient ☐ Parent/Legal Guardian ☐ Health Care Entity ☐ Other: _____

Reason for disclosure: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal

Form of distribution: ☐ Patient Pick-up ☐ Mail/delivered to healthcare provider ☐ Fax healthcare provider

Records will be picked up by: ☐ Patient ☐ Parent/Patient Representative ☐ Legal Representative

Where is STRIC to send requested Medical Information?

Name: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Fax Number: _____

I understand that:

1. My treatment, payment, enrollment or eligibility of benefits may not be conditioned on signing this authorization.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Authorization will expire 180 days from the date of signature.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	Date:
Print Name of Patient/Patient's Representative:	Relationship to Patient:

FOR DEPARTMENT USE ONLY: Verification check #1: _____ Verification check#2 _____