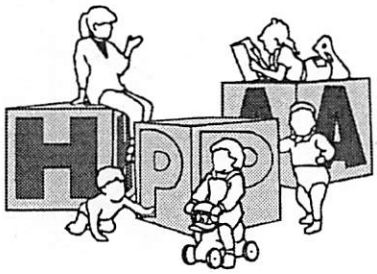

Harlingen Pediatrics Associates

Medical Records Release Form
(Please circle **Release** or **Request**)

Patient Name_____**DOB**_____

Address_____**Phone#**_____
Street **City, State, Zip**

By Signing this form, I hereby authorize the **RELEASE** or **REQUEST** of medical records **to and or from** the person(s) or entity below.

Name_____

Address_____

City_____**State**_____**Zip**_____

Phone_____**Fax**_____

Please **RELEASE** or **REQUEST** the following:
_____**Complete Medical Chart**_____**Immunization Records**_____**Other**_____

Your Initials are required to release the following information:
___Mental Health Records (excluding psychotherapy notes)
___Drug, Alcohol, or Substance Abuse Records
___Genetic Information (including Genetic Test Results)
___HIV/AIDS Test Results/Treatment
HIV/AIDS: I consent to the release of any positive or negative test for AIDS or HIV Infection, antibodies to AIDS or infection with any causative agent of AIDS with the rest of my medical records.

I, the undersigned, have read the above and authorized the staff of **Harlingen Pediatrics Associates** to disclose or request such information as herein contained. I understand that his consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other that the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information." Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization is for **(1)** conducting research related treatment, **(2)** obtaining information in connection with the eligibility for enrollment in a health plan, **(3)** determining an entity's obligation to pay a claim, or **(4)** creating health information to provide a third party.
This authorization expires one year from the date signed below.
I, understand that you will provide this information with **15 days** from the receipt and that **a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas Board if medical Examiners.**

ONCE YOU LEAVE OUR PRACTICE, YOU WILL NO LONGER BE ABLE TO RECEIVE MEDICAL CARE AT HPA.

_____
Signature of parent/guardian(patient if over 18 years of age.) Date

_____
Signature of witness

Maribelle Garza, M.D. • Francisco R. Papilla, M.D. • Erwin D. Sanchez, M.D. • Natalie Ayala, M.D.
Sally S. Villarreal, M.D • Stephanie R. Hinojosa, M.D. • Leticia Garcia, FNP-BC • Alicia Gonzalez, FNP-C

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