Medical Records Release Form

By signing this form, I authorize _____
Previous Physician/Clinic
Phone: (____) _____-_____ Fax: (____) _____-_____
to release confidential health information on:

Name _____ DOB ____/____/_____
Last First Middle

Please release copies of medical records to the person(s) or entity below:

Martin Garza M.D. P.A.
DLC Pediatrics
3521 W. Freddy Gonzalez Dr., Suite B
Edinburg, TX 78539
Phone: (956) 287-2100
Fax: (956) 287-2111

Please release or request the following information:

- ☐ **Immunization Records**
- ☐ **Sick Visits or Well Exams**
- ☐ **Complete Medical Chart**
- ☐ **Lab or X-ray reports**
- ☐ **Hospital Records**

Reason for Request: _____

HIV/AIDS: I consent to the release or request of any positive or negative test for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

/ /

Signature of parent/guardian Date
Witness: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charges according to rulings set forth by the Texas Board of Medical Examiners.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Office manager. I understand that this request may be withdrawn in writing at any time except to the extent that action has already been taken. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or: _____ condition. This authorization expires 90 days from the date signed and covers only treatment for the dates or diagnosis specified above.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form on order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.