AUTHORIZATION FOR RELEASE OF RECORDS

AUTORIZACION PARA LANZAMIENTO DE LOS RECORDS

Previous Doctors Office or Clinic:_____

Anterior Clinica de Doctor:_____

Address/Direccion:_____

Phone/Telefono:_____-_____-_____

Fax:_____-_____-_____

To release information to/Que le de informacion a:

Ancor Health Center, PA
818 N. Fourth St.
Longview, TX 75601
903-236-8600
Fax 903-236-8605

Patient Name/Nombre del paciente:_____

Date of Birth/Fecha de Nacimiento:_____

Information to be released/Informacion que se pueda dar:

__**Initial Examination**/Examinacion Inicial __**Discharge Summary**/Resumen de la descarga

__**Follow up Care Notes**/Notas de seguimiento __**Offical Visit Notes**/Notas de Oficina

__**Special Procedure Results**/Notas de Procedimientos __**ALL RECORDS**/Todo el Expediente

The above information is released for the following purpose and that purpose only, and other use is forbidden: Establish Care with ANCOR HEALTH CARE CENTER. All medical records regarding treatment, hospitalization and outpatient care for my condition including, but not limited to psychological, psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV antibody testing.

This authorization will expire (30) days from the date of my signature or as otherwish specified by date, event, or condition as follows:

Parents Signature/Firma de madre/padre:_____

Relationship to Patient/Relacion al paciente:_____

Date/Fecha:_____

Witness/Testigo:_____