I hereby authorize use or disclosure of the named individual's health information as described below.

SOUTH TEXAS HEALTH SYSTEM CLINICS

Patient Name	Date of Birth	Social Security Number

Address (Street, City, State, Zip Code)	Telephone Number

The following individual or organization is authorized to make the disclosure:

This information may be disclosed to and used by the following individual organization:

Name:_____ Address:_____

Phone:_____ Fax#:_____

Treatment dates:	Purpose of Request:

The following information is to be disclosed: (please check)

- ☐ Complete Record
- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultations (including psychiatric evaluations)
- ☐ Operative Report or Procedure Reports
- ☐ Emergency Department Record
- ☐ Laboratory Reports (including drug screens)
- ☐ Radiology or Imaging Reports/Films/CDs
- ☐ Cardiac Studies
- ☐ Interdisciplinary Records (Progress Notes)
- ☐ Medication Records
- ☐ Nursing Notes
- ☐ Physician Orders
- ☐ Pathology Reports
- ☐ Face Sheet
- ☐ Itemized Billing Records
- ☐ Other _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do by submitting a written request to Valley Care Clinics. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

Unless a shorter time frame is specified, this authorization will expire in 180 days, in accordance with Texas law.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules. You are prohibited from making further disclosure of it without the specific written consent of the person to whom it pertains.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. If I have any questions about disclosure of my health information, I can contact **STHS Clinics @ 956-388-2193.**

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient