WESTOVER HILLS CLINIC
1911 Rogers Road
San Antonio, Texas 78251
Hours: Mon. - Fri. 8:30 A.M. to 5 P.M.
PH.210-523-9933 FAX (210)647-0242

CAROLINE HERNANDEZ MD-INTERNANAL MEDICINE
JERRY LEE BURRIS, FNP *
www.westoverhillsclinic.com

AUTHORIZATION AND CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date: _____

I hereby authorize:

Person or entity name: _____

Address: _____

Phone: (___) _____ Fax: (___)_____

To release the following:

_____ Last 3 progress notes _____ Last labs _____ Drug Abuse _____Psychiatric ____HIV/Aids____ Other_____ __

Patient Name: _____

DOB: _____ SSN: _____

Patient or Legal Representative Signature: _____

I understand that this authorization will allow Westover Hills Clinic and its affiliates to use or disclose my protected health information. I understand that my medical record may contain sensitive information such as mental health, HIV, AIDS, substance abuse, Sexual and or other related conditions. I understand that these records are classified as privileged and confidential and cannot be re-released to me or to those designated by me or my legal guardian without an express and informed written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative as provided by state or federal law

This authorization remains effective until _____ (up to six months) at which time authorization expires.

I also understand that I have the right to revoke this authorization in writing at anytime by submitting a written notification to Westover Hills Clinic, attention Medical Release Correspondent.

Information used or disclosed by this authorization may be subjected to subsequent disclosure by the recipient and no longer be protected by this rule.

Caroline Hernandez, MD
Board Certified Internal Medicine