Medical Clinic HELOTES
Adult & Geriatric Specialist

Office Information:
12002 Bandera Road, Suite 111
Helotes, Texas 78023
P: (210) 695-9002
F: (210) 695-9044

# Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated healthcare providers.

**Disclosing Physician / Practice:** _____ Phone: (_____) _____-_____

**Description of Information to be disclosed:**

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Labs Reports / Tests
_____ Nuclear Stress Test
_____ EKG Test / Results
_____ Holter Monitor Results

**Protected Health Information to be disclosed to:**

**ALEJANDRO ARIZMENDI, MD PLLC**
**Attn: MEDICAL RECORDS**
**12002 BANDERA ROAD, SUITE 111**
**HELOTES, TX 78023**
**PHONE: (210) 695-9002**

**Purpose of Disclosure:**

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

**I understand the following:**

1). I may revoke this authorization at any time by providing written notice to Alejandro Arizmendi, M.D., PLLC.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). Alejandro Arizmendi, M.D., PLLC will not condition treatment or payment based upon my signing of this Authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by Alejandro Arizmendi, M.D., PLLC. and no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature | Date | Name (if other than Patient)