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BOARD CERTIFIED, CARDIOVASCULAR DISEASE

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO
INDIVIDUALS/FAMILY MEMBERS**

In accordance with Federal government privacy rules implemented through the Healthcare Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. **The Practice has posted the Patient's Rights and Patient Responsibilities in the waiting room.** A copy of these Rights and Responsibilities will be provided if so requested.

_____ I **DO NOT AUTHORIZE** the Practice to release any or all information concerning my medical condition to any individuals or organizations not involved in Treatment, Payment or Healthcare Operations as related to care or services provided by Alamo Heart Associates, P.A.

_____ I **AUTHORIZE** the Practice to **VERBALLY** release any or all information concerning my medical condition to the individual(s) or organization(s) listed below (In addition to any involved in Treatment, Payment or Healthcare Operations as related to care or services provided by Alamo Heart Associates, P.A.)

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Patient or Legally Responsible Party's Signature

Date

Witness

Date

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