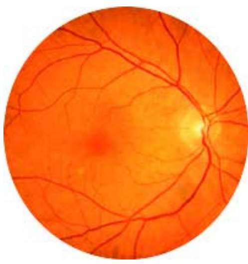

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Comprehensive Ophthalmology
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Ricardo Sepulveda, M.D.

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Webster/Clear Lake
15 Professional Park
Webster, Texas 77598
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MEDICAL HEALTH RECORD RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the person(s) or entity listed below. Limitations on the information you may release subject to this Release Form are as follows:

Patient Name: ________________________ Patient Date of Birth: ____________________

Patient SS# (last 2 digits only): __________ Patient Contact Number: ____________________

Doctor or Facility to release records:____

Release my protected health information to the following person(s)/entity:

Name:__________________________ Contact Number: ____________________

DATES OF SERVICE:____

Address:____

City State Zip

The reason or purposes for this release of information are as follows:

____

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. **I understand** that I have the right to revoke this authorization at any time in writing and present it to the organization releasing the information. **I understand** that the revocation will not apply to my insurance company or other providers who are participating in my healthcare treatments. **Unless an expiration date is specified, this authorization will expire is 6 months.** Expiration date:______________________________

I understand that authorizing this disclosure of health information is voluntary. **I understand** that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dalia Deleon, Privacy Officer for Charles A. Garcia, M.D., P.A..

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO THE PATIENT: I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information. I will not hold Charles A. Garcia, MD, P.A. or my provider(s) liable for any misinterpretation of the information in my medical record as a result of not consulting with my physician for the correct interpretation. **Initial:** _______ **Date:** ____________

______________________________ ______________________________

Printed name of patient or legal guardian Signature of patient or legal guardian

______________________________ ______________________________

Relationship to patient (if legal guardian) **Date**