Patient's Name:_____
D.O.B: ____/____/_____

Authorization to Release Medical Records

Dear Dr. _____
Phone Number:_____--_____
Fax Number : _____--_____

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:
_____Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s)
_____
Other. Specify: _____
_____Confer with other person orally about information in my medical record

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.
Initial :_____ Date _____

to the following person(s):
CRISCAR P.A.
Mariela Fuenmayor, MD.
3215 Steck Ave. Suite 205.
Austin, TX 78757
Phone: 512-467 2500 Fax: 512-467 2502

The reasons or purposes for this release of information are:
_____
I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

Signed:_____Date: _____
(Patient or person legally authorized to consent on patient's behalf)