Alamo Mental Health Group
Authorization for Release of Confidential Information
4242 Medical Dr., Ste. 6300, San Antonio, TX. 78229
Phone: (210) 614-8400 Fax: (210) 614-8165

Patient Name: _____DOB: _____

SS#: _____

1. I authorize _____/Alamo Mental Health Group to disclose the following health information about me:

_____ All Information/Records _____ Progress Notes _____ Billing Records

_____ Evaluation/Consultation Reports _____ Other _____

2. The information to be disclosed is from_____ to ____present/_____ (dates).

3. This information may be disclosed to (please give name and address of recipient):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phn/Fax: _____ Phn/Fax: _____

4. This information may be disclosed for the purpose of:

_____ Coordination of Care _____ Assistance/Support of Treatment

_____ Other _____

5. The information may be disclosed until (ending date) _____. If this date is left blank, the authorization will automatically expire one year from the date I sign below.

6. I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore I release Alamo Mental Health Group, its providers and staff from all liability arising from the disclosure of my Health information.

7. I understand that I may inspect or request copies of any information disclosed by this authorization.

8. I understand that I may revoke this authorization by notifying, in writing, AMHG/_____ except to the extent that action has already been taken on it.

9. I understand that I may decline to give authorization and that declining authorization to release information will not affect my ability to obtain treatment, payment, or my eligibility for benefits from AMHG.

10. _____ I **decline** to give authorization to release information at this time.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature if appropriate Relationship to Patient