J. Gabriel Guajardo, M.D.
When Caring for life, Every Stage Matters.

OBSTETRICS · GYNECOLOGY · INFERTILITY · INCONTINENCE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

Information to be released **FROM**:	Information to be released **TO**:
Facility Name: _____	Facility Name: J. Gabriel Guajardo, M.D., PLLC
_____	_____
Address: _____	Address: 100B Alton Gloor Blvd. #130
_____	Brownsville, TX 78526
Phone#: _____	Phone#: (956) 350-4821
Fax#: _____	Fax#: (956) 350-6718

Purpose of Release of PHI:

_____Continued Care _____Personal Use _____Legal _____Hospital _____Disability

_____Psychotherapy Notes _____Work Related Status / Disability

Description of information to be released:

_____Progress Notes including History and Physical
_____Laboratory Reports (including pathology reports)
_____Radiology Reports (ultrasounds/sonograms, X-Rays, CT Scans, MRI)
_____Consultations
_____Hospital Records: emergency records, admission/registration records, operative reports, discharge summary
_____Pathology Reports
_____Billing Records
_____Specific work related forms, FMLA, Disability, general work status/release.

I understand that:

- **Any information that was not generated by J. Gabriel Guajardo,M.D. will not be released and must be requested by that facility directly.**
- **This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify; I desire this authorization to be in effect until (Date) _____.**
- **By signing this form I am authorizing the release of my protected health information.**
- **I may revoke this authorization at any time with written notification, but will not affect information that has already been released or actions taken prior to the written revocation. Written revocation must be signed and dated with a date that is later than the date of this authorization.**
- **There may be a charge associated with the release of information services rendered.**
- **There is no charge for the release of information to other health care facilities.**
- **I understand that this authorization is voluntary and I may refuse to sign it.**

Patient Signature_____**Date**_____
Or Legal Representative

phone: 956.350.4821
fax: 956.350.6718
100B E. Alton Gloor Blvd., Suite 130,
Brownsville, TX 78526