AUTHORIZATION FOR RELEASE OF RECORDS
AUTORIZACION PARA EL LANZAMIENTO DE LOS RECORDS

Previous Doctors Office or Clinic: _____
Anterior Clinica de Doctor: _____
Address/Direccion:_____
Phone/Telefono: _____
Fax: _____

To release information to:/ que le de information a:

Ancor Health Center, PA
818 N. Fourth St.
Longview, TX 75601
(903) 236-8600
Fax (903) 236-8605

_____ _____
Patient Name (Please Print)/Nombre del paciente Social Security #/ Numero de Seguridad Social

_____ _____
Date/Fecha Date of Birth/Fecha de Nacimiento

Circle: Male/Masculino or Female/Femenina

Information to be released: / Information que se puede recibir:

_____ Initial examination/Examinacion Incial _____ Discharge Summary/Resumen de la Descarga

_____ Follow-up Care Progress Notes/Notas de Progreso _____ Office Visit Note/Notas de la Oficina

_____ Specia Procedure Results/Notas de Procedimientos _____ All Records/Todo El Expediente

The above information is released for the following purpose and that purpose only, and other use is forbidden: Establish Care with **ANCOR HEALTH CARE CENTER**. All medical records regarding treatment, hospitalization and outpatient care for my condition including, but not limited to psychological, psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV antibody testing. This authorization will expire (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:

Parents Signature/Firma de madre/padre: _____

Relationship to Patient/Relacion al paciente: _____

Address: _____

Telephone: _____

Date/Fecha: _____ Witness/Testigo: _____