VALLEY INTENSIVISTS, PULMONOLOGISTS AND SLEEP SPECIALISTS
1200 E. Savannah Ave. Suite 12
McAllen, TX 78503
Tel: (956) 688-6300 Fax: (956) 688-6303

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

DATE OF BIRTH: _____

Phone Number: _____

AUTHORIZATION

I authorize any current or prior healthcare provider, hospital, clinic, laboratory, pharmacy, or other healthcare entity to release my protected health information to:

Valley Intensivists, Pulmonologists and Sleep Specialists (VIPS)
Attn: Medical Records Department
Fax: (956) 688-6303

INFORMATION TO BE RELEASED

- ☐ Complete Medical Record
- ☐ Office Visit Notes
- ☐ Diagnostic Reports (X-ray, CT, Sleep Study, etc.)
- ☐ Lab Results
- ☐ Billing Records
- ☐ Other: _____

PATIENT RIGHTS

- I understand that I may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken.
- I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization.
- I understand that once my information is disclosed, it may no longer be protected under federal privacy regulations.

Patient / Legal Representative Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY
Date Authorization Received: _____