



ADVANCED INTERNAL MEDICINE PRACTICE

AIM for better health

### Authorization for Use and Disclosure of Medical Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorizations.*

#### Authorizations

I hereby authorize: \_\_\_\_\_  
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named healthcare provider may hold, by means of mail, fax or other electronic methods.

To: Advanced Internal Medicine Practice LLC.  
14327 Blanco Rd.,  
San Antonio, TX 78216  
Phone #: 210- 245-7933 Fax#: 731-201-5068  
Email: [aimprimarycaresa@gmail.com](mailto:aimprimarycaresa@gmail.com)

The medical information/ records will be used for the following purpose: Continuation of care.

This authorization is:

{ } Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment)  
{ } Limited to the following medical information: \_\_\_\_\_

I consent to the specific release of the following records:

Drug/Alcohol/ Substance Abuse \_\_\_\_\_(initials)                      HIV Diagnosis/ Treatment \_\_\_\_\_(initials)  
Psychiatric/ Mental Health \_\_\_\_\_(initials)                      Genetic Information \_\_\_\_\_(initials)  
Tests for Antibodies to HIV \_\_\_\_\_(initials)

#### Duration:

This authorization shall be effective immediately and remain in effect until \_\_\_\_\_(date)

#### Restrictions:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

\_\_\_\_\_  
Patient Name    Social Security #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature/ Patient Representative

\_\_\_\_\_  
Relationship to Patient

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San Antonio, Texas 78216

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