Samuel N. Landero, MD
Board Certified in Family Medicine
Board Certified in Obesity Medicine

Authorization for Release of Medical Information (Incoming)

I hereby authorize the release of information from the medical record of:

____

Patient Name | Date of Birth | Social Security Number

Information Released To:
Samuel Landero, MD
Arroyo Vista Family Medicine
1821 S. Sesame Square, Suite 2
Harlingen, TX 78550
Phone: (956) 412-2836
Fax: (956) 412-2837

From:
____
____
____

Please Release the Following:

For Dates: ______________________________

- ☐ Last ______ Progress Notes
- ☐ History/Physical Exam
- ☐ Lab Reports
- ☐ Diagnostic/X-Ray
- ☐ Immunization Records
- ☐ Other ____

Including Information (if applicable) pertaining to : ☐ Mental Health, ☐ Drug /Alcohol, ☐ HIV/AIDS

Purpose or Need for Disclosure:

- ☐ Continued Patient Care
- ☐ Insurance Claim/Application
- ☐ Disability Determination
- ☐ Attorney/Legal
- ☐ Other ____
  ____

I understand the following (See CFR§ 164.508(c)(2)(i-iii)):

a. This authorization is voluntary and I can refuse to release some or all of my records. However, I understand such refusals may result in improper diagnosis, improper treatment, and denial of insurance coverage or have other negative consequences.
b. Arroyo Vista Family Medicine cannot control people or organizations receiving this information to prevent re-release of it without my approval.
c. I have the right to revoke this authorization in writing at any time by notifying Arroyo Vista Family Medicine at 1821 S. Sesame Square, Suite #2, Harlingen, TX 78550. However, stopping this Release of Information will not affect any information released prior to revoking my authorization for release.

X ____

Signature of Patient or Patient's Legal Representative | Relationship to Patient or Legal Authority

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Witness | Date