# San Antonio Family Psychiatry

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**RELEASE OF HEALTHCARE INFORMATION**

**Patient Name**: _____ **Birth Date**: _____

I request and authorize Amber Mansoor, MD to **obtain/release** all of my health care information and records including (check appropriate):
___billing records
___medical records

for the reason/purpose of:
_____
_____

## FROM/TO:

**Name of Physician, Psychotherapist, School or Other:**

_____

**Address:** _____

**City, State:** _____ **Zip code**: _____

**Tel. Number**: _____

**Fax. Number**: _____

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I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written statement of revocation to Amber Mansoor, MD. I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal privacy regulations.

**Signature** (Patient or authorized representative)_____**Date**:_____

Relationship/authority (if signed by authorized representative): _____

Please contact us if this is received by you in error. Thank you.