Genesis Behavioral Health

MEDICAL RECORDS RELEASE OF INFORMATION

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Name of Patient (Please Print) Date of Birth Cell/Phone #

I hereby authorize: **Genesis Behavioral Health**

To: ☐ Release information to: Name: _____

☐ Obtain information from: Address: _____

_____

_____

Phone: _____

Fax: _____

The purpose for this disclosure is: _____

This request is to include information from: _____/_____/_____ - _____/_____/_____.

I understand that this authorization may include information related to Genesis Behavioral Health, Genetic Testing, Treatment and Testing for drug or alcohol abuse, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), and sexually transmitted diseases.

This authorization is valid unless otherwise indicated. I understand I may cancel this authorization at any time by written authorization. I hereby release Genesis Behavioral Health and its personnel from all legal responsibility that may arise from the act that I have authorized above. Genesis Behavioral Health is not responsible for completeness, legibility or omissions used by the copying of any medical records from another institution.

_____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative Relationship to Patient

7122 Stonewall Hill, San Antonio, TX 78256 Office: (210) 404-9696 Fax: (210) 404-9466