Victor D. Vela, M.D., P.A.
1201 South Main, #114 • Boerne, Texas 78006
Tele. 830-816-6844 • Fax 830-816-6922

Authorization for Release of Confidential Information

I hereby authorize (Dr./Grp)____ to release medical information including, if any, psychiatric or psychological information, infectious or contagious disease information (including HIV/AIDS confidential information), and/or information about drug or alcohol abuse or treatment of same from the health record(s) of:

SS#____

Patient____ DOB________________________

Address____

City/State____

TO BE RELEASED FROM:
Please list the names and addresses of your prior physicians.
For Military records: Please list sponsor's social security number, date of birth and name of military base.

TO BE RELEASED TO: **Victor D. Vela, M.D., P.A.**
1201 South Main, #114
Boerne, Texas 78006

This authorization covers patient care given from ______________ to ______________.

Also release the following:

_____Living Will
_____Durable Power of Attorney of Healthcare
_____Do Not Have Either

Purpose of Disclosure:

_____Medical Care _____Attorney
_____Insurance _____Other

I understand that this consent shall automatically expire one hundred twenty (120) days from the date set forth below. The patient can revoke this authorization in writing at anytime prior to the expiration date.

____
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE

____
WITNESS

____
RELATIONSHIP TO PATIENT

____
DATE

____
DATE