MERCY WELLNESS CLINIC
FAMILY PRACTICE

Part 1: Patient Information:

Name:____ SS#:____

Date of Birth:__________________________________ Phone #: ___________________________________

Part 2: What information are we requesting? (Mark all that apply)

Provider Name/Clinic (that we are sending the request to): ____

Phone:____________________________________ Fax:____

Dates of Treatment Requested (please circle): Any & All Dates | Specific Dates:____________________

- ☐ All health information (all on file)
- ☐ Consultation reports
- ☐ Diagnostic test reports
- ☐ Discharge summary
- ☐ Emergency department records
- ☐ EKGs/cardiology reports
- ☐ History & Physical
- ☐ Laboratory reports
- ☐ Operative reports
- ☐ Past/Present medications
- ☐ Pathology reports
- ☐ Patient allergies
- ☐ Physical/Occupational Therapy reports
- ☐ Progress notes/reports
- ☐ Radiology reports & imaging
- ☐ Other (Specify): ________________

Please initial the following items in order for us to obtain your medical records:

_____Mental Health Records (excluding psychotherapy notes)

_____ Drug, Alcohol, or Substance Abuse Records

_____Genetic Information (including genetic testing results)

_____HIV/AIDS Test Results/Treatment

Part 3: Reason for Disclosure.

Mercy Wellnessness Clinic is requesting the above-listed medical records for treatment and continued medical care of the above-listed patient.

Part 4:Release Medical Information to *(please check one box, as all of our offices share an EMR system)*

☐ **Mercy Wellness Clinic- Spring Branch Location (Main Office)**
18568 Forty-Six Parkway #1001 Spring Branch, Texas 78070
Phone: 830-438-9300, stay on the line
Fax: 830-438-9002 (same fax number for all offices)

☐ **Mercy Wellness Clinic- Alamo Ranch Location**
11911 Culebra Road #107 San Antonio, Texas 78253
Phone: 830-438-9300 Ext: 200

☐ **Mercy Wellness Clinic- Boerne Location**
134 Menger Springs #1230 Boerne, Texas 78006
Phone: 830-438-9300 Ext: 108

Please Continue onto the following page

I hereby authorize Mercy Wellness Clinic to obtain the health information indicated above that is contained in my patient records to the Recipient name above. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. The authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.**

Signature: ____ Date: _____________________________

Signature of Individual or Individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable) ___________________________________

If Representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Health Care Power of Attorney ☐ Other: ____