CROSSROADS HEALTH CENTER
4504 N. LAURENT
VICTORIA, TEXAS 77901
TEL. 361-573-9999 FAX 361-573-9973

Medical Information Release Form **(This entitles Crossroads Health Center to release information to other's besides yourself, which also includes verbally (Ex: Wife, Husband, Grandparents, Etc.)**

This authorizes Crossroads Health Center to provide a copy, summary, or narrative of my medical information or otherwise release confidential information to the following parties:

Name:_____ Relationship:_____

Date of Birth:_____/_____/_____

Phone Number: (_____)-_____-_____ Alternate Phone: (____)-_____-_____

Address:_____

City:_____ State:_____ Zip:_____

Name:_____ Relationship:_____

Date of Birth:_____/_____/_____

Phone Number: (_____)-_____-_____ Alternate Phone: (____)-_____-_____

Address:_____

City:_____ State:_____ Zip:_____

Name:_____ Relationship:_____

Date of Birth:_____/_____/_____

Phone Number: (_____)-_____-_____ Alternate Phone: (____)-_____-_____

Address:_____

City:_____ State:_____ Zip:_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Signature:_____ Date____/____/____

Patient Signature: _____ Date____/____/_____