

# PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

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## REQUEST FOR RELEASE OF MEDICAL RECORDS

**Requesting only: (circle one)**

Immunization records  
Insurance information  
Labs/x-rays other: \_\_\_\_\_

Physical form  
All records

**HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please send records requested (circle one)**

**TO**

**FROM**

Clinic/Hospital/ School name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Reason for records release: \_\_\_\_\_

For period of: \_\_\_\_\_

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip code: \_\_\_\_\_

Social security: \_\_\_\_\_

Responsible party name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Federal Law, Health Insurance Portability and Accountability Act (HIPAA) and will be reported as such. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners