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BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY
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Authorization for the Use or Release of Protected Health Information

I authorize the following information to be released from the medical record of:

Patient Name:_____Date of Birth: _____

SS# _____

Release: ☐ TO ☐ FROM

_____ _____
Name Address

_____ _____
City State Zip Phone Fax

PLEASE CHECK INFORMATION TO BE RELEASED

☐ History and Physical	☐ All Medical Records	☐ Pap Smear
☐ Progress Notes	☐ Emergency Room Records	☐ Ultrasounds
☐ OB Records	☐ Consult Records	☐ Lab Reports
☐ X-Rays	☐ Mammogram Reports	☐ Other_____

COVERING PERIOD FROM: _____ TO: _____

This protected health information is being used or disclosed for the purpose of **Medical Care.** This authorization is effective for period of (90) days from the signature date or as otherwise specified: _____(Expiration date), after the expiration date, the authorization to use or disclose this protected health information is no longer valid.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office's privacy officer. Please send your letter to Serrano Ob-Gyn located at 20726 Stone Oak Parkway, Suite 101, San Antonio, Texas 78258.

I understand that if I later revoke this authorization, the revocation is not effective for uses or disclosures that the Office has made in reliance on my authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

☐ PATIENT DECLINES AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____ _____
Signature of patient / Legal guardian Relationship to patient Date