Austin Springs Women's Health

MEDICAL RECORD RELEASE

Printed Name: _____ Date of Birth: _____

Address: _____ SSN: _____

Other Names: _____ Phone #: _____

Information to be Release-Covering the Following Periods of Health Care

From Date: _____ To Date: _____

Please check type of information to be released:

☐ **Entire Medical** ☐ Pathology/Lab Reports ☐ Other_____

☐ Consultations/Progress Reports ☐ Prenatal Records and Lab Only ☐ Last 3 year of Medical Records

Purpose of Request: ☐ Treatment or Consultation ☐ At the request of the patient ☐ **Continuing Care.**

Person Authorized to Release Information:

Provider:_____

Phone: _____

Fax: _____

Person Receiving Medical Records:

Provider: _____

Phone: _____

Fax: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AID Records Release:

I understand that if my medical or billing records contains information in reference to drug and/or alcohol abuse, psychiatric care and/or, sexually transmitted disease, Hepatitis B or C and/or other sensitive information, I agree to its release ■ **yes** ■ no

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at: 4007 James Casey St. Suite A240 Austin, TX 78745.

Unless revoked, this authorization will expire on the following date or event _____. If no expiration is set forth, this authorization will expire 180 days from date of signature.

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This facility, it's employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated any authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that I may not condition my treatment on whether I sign this authorization from unless specified above under "Purpose or Request''. I can inspect or copy the protected health information to be used or disclosed. I authorized Dr. Martha Schmitz, employed staff, and any affiliated Clinics to use and disclose protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not the Patient: _____ Date: _____