SOUTHEAST TEXAS OB/GYN ASSOCIATES, P.A.

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Medical Record #

Authorization to Release Medical Information

Patient Name_____ Other Name_____

Birthdate_____

Current Address_____

Daytime Phone #_____ Social Security #_____

REASON FOR RECORD
- ❑ Personal
- ❑ Medical Care
- ❑ Benefits
- ❑ Litigation
- ❑ Workman's Comp
- ❑ Other _____

I AUTHORIZE INFORMATION RELEASE FROM:

Name of Facility and Physician

Phone Number Fax Number

Address

City, State, Zip

PLEASE SEND MY RECORDS TO:

Facility to Receive Information and Physician

Phone Number Fax Number

Address

City, State, Zip

Type of Information to be Released

❑ Specific Information Only Please

___ PAP Results
___ Mammogram Reports
___ Medications / Therapy
___ Lab
___ Radiology Reports
___ History and Physical
___ Genetics / Amniocentesis
___ Immunizations
___ OB / GYN Records
___ Other_____
___ Operative Report Dates_____
___ Pathology Report Dates_____
___ Ultrasound Report Dates_____

❑ General Medical Records (from the past two years only)

Notes:

Protected or Sensitive Information

Certain information cannot be released without specific authorization. Please initial below **if you agree to release the following:**

_____ Initials I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ Initials I recognize that the information disclosed may contain MENTAL HEALTH information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ Initials I recognize that the information disclosed may contain data regarding HIV/AIDS testing. I specifically consent to disclosure of such information.

_____ Initials I recognize that the information disclosed may contain data regarding GENETIC TESTING. I specifically consent to disclosure of such information.

Permission to Fax Information: ❑ Yes ❑ No

_____ Initials I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event)_____

THERE MAY BE FEES FOR PROVIDING COPIES.

Signature of Patient or Patient's Legal Representative

Date