NEW BEGINNINGS
OB-GYN

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO:_____
(Doctor or Hospital)

_____
(Address)

PHONE:_____FAX: _____

You are hereby authorized and requested to release to:

New Beginnings OB-GYN PLLC
129 Vision Park Blvd, Suite 310
Shenandoah, Texas
77384
Phone: 936-441-8635
Fax: 936-756-4288

the following sections of medical records on:

PATIENT: _____

DOB:_____SSN: _____

_____ All
_____ History and Physical
_____ Discharge Summary
_____ Operative/Pathology Report
_____ Consultation
_____ Laboratory Reports
_____ Radiology Reports
_____ Other, please specify _____

I understand any of the above requested information may include results of HIV test, if one was performed. _____
Initial

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

_____ _____
Signature of Patient (or guardian) Date