Hill Country OB/GYN Associates
9805 Brodie Lane, Austin, TX 78748
Office: (512) 462-1936 Fax: (512) 394-9388

Authorization for Release of Information

In accordance with legal and regulatory agency requirements, the health record is the property of Hill Country OB/GYN Associates.

A fee of $25.00 is charged only when records are released directly to the patient and/or attorney, insurance, disability, etc. There is no fee for records sent directly to a physician or medical facility.

Please complete ALL information in order to process your request in a timely manner.

Patient Information:

Patient Name: ______________________ DOB: ______________

Last four digits of your Social Security #: *** - ** -

Release Records From:

Hill Country OB/GYN Associates

☐ Ana Eduardo ☐ Margaret Landwermeyer ☐ Lisa Schneider ☐ Chris Hart
☐ Melissa Quinn ☐ Leah Mello ☐ Amanda DiSarro

☐ Physician or Medical Facility Name: ______________________
Phone Number: ______________________
Fax Number: ______________________
Address: ______________________

Release Records To:

Hill Country OB/GYN Associates

☐ Ana Eduardo ☐ Margaret Landwermeyer ☐ Lisa Schneider ☐ Chris Hart
☐ Melissa Quinn ☐ Leah Mello ☐ Amanda DiSarro ☐ **Myself for Personal Use**

☐ Physician or Medical Facility Name: ______________________
Phone Number: ______________________
Fax Number: ______________________
Address: ______________________

Please Release the Following:

☐ Most recent office visit / test results
☐ Mammogram results Year ______________
☐ Lab results
☐ Date Range___/___/___ to ___/___/___
☐ Pap Smear results Year ______________
☐ HIV
☐ Entire Record
☐ Medication record
☐ US/ Xrays
☐ OB Records
☐ Current pregnancy
☐ Previous pregnancy/delivered ___/___/___
☐ Specific: ______________________

A date range must be provided. If not indicated, only the last date of service will be sent.

Purpose or Need for Disclosure:

☐ Transferring Care	☐ Attorney/legal	☐ Primary Care Physician
☐ Disability Determination	☐ Insurance	☐ Midwife
☐ Current Pregnancy Only	☐ Other:	

I understand that: The information released is for the specific purpose stated above. I will not hold Hill Country OB/GYN Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I also understand that my medical records may contain reports that only a physician can interpret. I may revoke this authorization at any time by notifying Hill Country OBGYN. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. I further understand that I will not be able to make appointments or seek medical advice from Hill Country OBGYN two weeks after my medical records have been sent.

Patient Signature: ______________________ **Date Requested:** ______________

Appointment Date & Time: ______________________