690 S Loop 336 W, Suite 220, Conroe, TX 77304
Phone : 936-441-7100 Fax : 936-756-7105, Email : info@solacewomenscare.com

Informed Authorization and Consent for the Release of Medical Records

I hereby authorize Solace Women's Care to obtain the medical records of

Patient Name: _____Date of Birth: _____

Address: _____

Social Security #: _____ Phone #: _____

( ) RELEASE TO:_____ ( ) OBTAIN FROM: _____

_____ _____

_____ _____

Phone:_____ Phone:_____

For the purpose of: _____

Information to be disclosed: Medical Records for Date(s) of Service Requested: _____

____ Entire Medical Records ___ Laboratory Results ___ Pathology

____ Operative Reports ___ Other ___ Discharge Summary

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing and/or HIV testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity (ies) as stated above.

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature. I do not authorize further release to a third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the redisclosure of that information. I further release the attending physician(s) and his associates of Solace Women's Care and its staff from any liability arising from this release of this information.

Authorization: I authorize the above provider to release the information marked above to the reciepient.

_____ _____

Signature of Patient or Guardian Relationship to Patient

_____

Date