

Medical Record Release

Printed Name: _____ Date of Birth: ____/____/____

Address: _____ Social Security #: ____ - ____ - ____

Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

- | | |
|--|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory Test Results/Reports | <input type="checkbox"/> Radiology Report(s) |
| <input type="checkbox"/> Other (specify) _____ | |

Purpose of Request:

- Treatment or Consultation At the Request of the Patient Continuing Care

Person Authorized to Release Information:

Name: _____
Phone/Fax: _____
Attention: _____

Person Receiving Medical Records

Name: **John Thoppil, MD**
Fax: **512-605-3800**
Phone: **512-473-8300**

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

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and/or other sensitive information, I agree to its release. Check one: Yes No _____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS testing and/or treatment I agree to its release. Check one: Yes No _____ Initials

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 6611 River Place Blvd. Ste. 202, Austin, Texas 78730

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, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and 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 form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize River Place OB/GYN, PA to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not Patient: _____

6611 River Place Blvd
Austin, Texas 78730

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Fax: (512) 605 3800
www.RiverPlaceOBG.com