



Patient Information

Patient Full Name: Date of Birth: Patient Address: Home Phone: City: State Zip: Work Phone:

Release Information To

I hereby authorize Hill Country OB/GYN Associates to release my medical record information to: Mail Copies To: Discuss Medical Information With: Name/Facility: Attention: Address: Phone: City: State Zip: Fax: Purpose: Personal Continuing Care/ Referral Insurance Legal Transfer (Explain) Other (Explain) Comments/ Authorization Specifications:

NOTICE: The information released pursuant to this Authorization may be re-disclosed by the receiving institution or individual to other individuals or organizations that are not subject to federal and/or state Hill Country OB/GYN Associates will not condition treatment on the signing of this Authorization or payment of associated fees.

Information to be Released

Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics) Please provide only the following records within the date range listed below: Progress Notes/Consults Labs Radiology Reports Pathology Billing Other (Explain Below) From To From To

Comments/ Authorization Specifications:

NOTICE: This Authorization is valid for 180 unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department Hill Country OB/GYN Associates, except to the extent that Hill Country OB/GYN Associates has already completed action on it.

POTENTIAL FEES: See the "Fee and Process Explanation Letter" for more information regarding associated costs.

Authorization to Release Protected Information

REQUIRED: Please complete the check boxes below indicating how protected information should be handled, even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one

Initial below to confirm your choice

I DO DO NOT want information about communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

STOP AND REVIEW: Please confirm that you have put a checkmark and initialed the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here

Date Here

Patient's Signature Date Parent/Legally Recognized Representative Signature Date Description and Proof of Authority to Act on Patient's Behalf

Know Your Rights Refer to the HIPAA "Notice of Privacy Practices"

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