Hill Country OB/GYN Associates

Authorization For Use or Disclosure of Medical Record Information
Hill Country OB/GYN Associates

sharecare | HEALTH DATA SERVICES

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: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose - Choose an Item:

○ Email Address: _____ Format - Choose an Item:

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 my entire medical record for dates: From _____ To _____

○ Please provide my entire billing record for dates: From _____ To _____

○ 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 _____

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

Records Release? Check one 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

Patient's Signature **Date**

Parent/Legally Recognized Representative Signature **Date**

Description and Proof of Authority to Act on Patient's Behalf

Date Here

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

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SUBMIT **PRINT**