



Hill Country OB/GYN Associates

9805 Brodie Lane, Austin, TX 78748

Office: (512) 462-1936 Fax: (512) 394-9388

Authorization for Request of Information To Hill Country OB/GYN Associates

Patient Information	
Patient Name: _____	DOB: _____
Request Records From	
Physician or Medical Facility Name: _____	
Phone Number: _____	
Fax Number: _____	
Address: _____	
Release Records To Hill Country OB/GYN Associates	
Physician:	Choose an item.
Please Release the Following:	
Release:	Choose an item.
Dates Needed:	_____
Specific/Comment:	_____

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.

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.

Patient Signature: _____ **Date Requested:** _____

Appointment Date & Time: _____