PALO ALTO
Women's Health
CENTER

Authorization to Release Medical Information
Please fax Records to 210 922-3339

I AUTHORIZE:	TO RELEASE TO:
_____ Name of receiving person/organization	Palo Alto Women's Health Center
Street Address _____	102 Palo Alto Road, Suite 230,
_____	San Antonio, TX 78211
Phone: _____	Phone: (210) 922-3331

Patient's Name: _____ Date of Birth: _____ SS#: _____

INFORMATION TO BE RELEASED: (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports

☐ Electrocardiogram (EKG) ☐ Ultrasound report ☐ prenatal records ☐ other: _____

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By signing below, you are authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Signature:_____

If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RECORDS FROM THE PERIOD: _____/_____/_____ to _____/_____/_____

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal

☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

I understand that this authorization shall be valid for **one year**. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

Patient's Signature: _____Date: _____

The requestor may be provided with a copy of this authorization