

WOMEN CARING FOR WOMEN OBGYN
8335 Walnut Hill Ln., Ste 215
Dallas, TX 75231
Office: 214-221-2227
Fax: 214-221-2219

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ Date(s) of Service: _____
Date of Birth: _____ Social Security Number: _____

I, the undersigned, authorize the release if or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

- Continuing Medical Care
- Insurance
- Personal Use
- Legal Purposes

INFORMATION TO BE RELEASED OR ACCESSED:

- Radiology Studies (Ultrasound, CT, MRI, etc.)
- Laboratory studies (including pap, biopsies)
- Surgical records (OP notes & path reports)
- Prenatal records for current pregnancy
- Previous treatment received

(Name of Doctor/Hospital to release information)

(Phone number) (Fax number)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that I may be charged a retrieval/processing fee for personal copies of my medical records.

This authorization will expire 180 days from the date of my signature.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

Printed Name of Patient or Representative

Relationship to Patient