Medical Records Authorization Form

(***Choose One***)
Release To: Request From:

(***Choose One***)
Release To: Request From:

Comprehensive OBGYN

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Phone (214)733-8001 Fax (972)838-1360

Name: _____

Address: _____

Address: _____

City: _____ State ____ Zip _____

Phone: _____

Fax: _____

*****The information provided above is *only the patient* if we are sending your records to you directly, otherwise *please list the physician* who currently has your records or is intended to receive your records*****

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

I authorize the above listed physician/facility/firm/entity and/or its agents/representatives/employees to release, for inspection and copying, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from the dates of _____ to _____. I understand this authorization can be revoked in writing, submitted to the Privacy Offical, at any time, until the records have been sent. This authorization will expire in 180 days unless otherwise indicated or revoked: _____.

I understand this authorization hereby releases the above listed physician / facility / firm / entity and/or its agents / representatives / employees from any legal responsibility or liability for disclosure of the PHI being released to the recipient indicated above. The potential re-disclosure of this information is the responsibility of the aforementioned recipient. The original physician / facility / firm / entity will continue to protect the original record under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand I do not have to sign this authorization to receive treatment and payment for services will not be denied if I do not sign this form unless specified below by the Reason for Requesting Records. I can view or receive a copy of the protected health information to be used or disclosed.

□ Entire Record □ Progress Notes □ Lab Reports □ Pathology Reports □ MRI/CT/Sono/XRay Reports

□ Operative Notes □ Emergency Room Reports/Records □ Labor and Delivery Records □ Other _____

Reason for Requesting Records: _____

_____ Date: _____
Patient/Representative Signature Printed Name of Representative

_____ Date: _____
Witness Signature Printed Name of Witness

****Special Authorization*****

I recognize my records pertaining to mental health and HIV/AIDS is protected separately from my general medical records and hereby authorize the release of these records in the same manner the records above are released.

_____ Date: _____
Patient/Representative Signature Printed Name of Representative