

Caring Center For Women of Central Texas
 705 Generations Drive, Suite # 101
 New Braunfels, Texas 78130
Phone (830) 387-4790
Fax (844) 560-1249

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____
 Patient Address: _____

Authorization for Release

I hereby authorize **Caring Center For Women of Central Texas** to disclose records obtained in the course of my evaluation and/or treatment to:

Physician's Name/Facility: _____ Phone: _____
 Address: _____ Fax #: _____

Disclosure will include (**check all that apply**) ALL record information Dates: _____
 History & Physical Lab Reports Progress/Physician Notes Pathology Reports
 Operative Reports Radiology Reports Other: _____

Please initial on each line below to include these specific records in this request. **I understand that failure to initial the four (4) items below, indicates that I do not want or authorize those specific records to be released.**

- _____ Diagnosis evaluation and/or treatment for alcohol and/or drug abuse.
- _____ Records related to HIV testing and results and/or AIDS diagnosis or treatment.
- _____ Psychiatric and/or psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including any narrative summaries, tests, social work assessment, medications, psychiatric examination, progress notes, consultations, and/or treatment plans.
- _____ Records related to Genetic testing and results.

I also understand the following:

I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for my health care provider to inform the requester that portions of the record have been withheld.

- This authorization shall remain valid unless revoked and will expire 1 year after signing. This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee the recipient will not redisclose my health information to a third party not subject to applicable federal and state law governing the use and disclosure of my health information.
- I understand that signing this authorization is voluntary and will not condition my treatment, payment, enrollment or eligibility of benefits.

Signature of Patient or Substitute Decision Maker **Date**

If Substitute Decision Maker, state relationship **If Substitute Decision Maker, state reason**

<p style="text-align: center;">Reason for Request:</p> <p>____ Moving Out of State</p> <p>____ No Insurance</p> <p>____ New Caring Center For Women of Central Texas Patient</p> <p>____ Personal Records</p> <p>____ Transferring Care</p> <p>REASON: _____</p>	<p style="text-align: center;">Method of Disclosure:</p> <p>____ Mail to above patient address ____ Hand delivered to patient</p> <p>____ Mail to above provider ____ Fax to above provider</p> <p>____ Electronic Transfer</p> <hr/> <p style="text-align: center;">PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HAND DELIVERED RECORDS</p> <p style="text-align: center;">_____ Signature _____ Date</p>
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