CARING CENTER FOR WOMEN PA

705 Generations Drive, Suite # 101
New Braunfels, Texas 78130
Phone (830) 387-4790
Fax (512) 396-7555

RELEASE OF MEDICAL RECORDS

Patient Information

Name: _____

Address: _____

City, State & Zip: _____

DOB: _____

Authorization for Release

I, hereby authorize:

Name: _____ Phone: _____

Address: _____ Fax #: _____

To release, disclose, and deliver the medical information described below to:

Name: _____ Phone: _____

Address: _____ Fax #: _____

PLEASE INCLUDE THE FOLLOWING:

____ Prenatal Records

____ Office Visits

____ Operative Reports From _____ To _____

____ Hospital Reports From _____ To _____

____ Lab/Radiology Reports

____ Pathology Reports

Purpose of Release:

Personal Use Legal Purposes Insurance Continuity of Care

I specifically authorize the release of all medical information relating to the above named patient including but not limited to the following categories protected by the state of federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS related information, if such information is contained in the records. This request includes any report, correspondence, test results, and if any other information contained in the records, whether generated by the authorized provider or another entity.

I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above, I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality.

I authorize the release of the information as indicated above

Signature: _____ Date Signed: _____