SAN MARCOS www.caringcenterforwomen.com NEW BRAUNFELS

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New Braunfels, TX 78130
P: 830-387-4790

RELEASE OF MEDICAL RECORDS

Patient Information

Name: ______________________________

Address: ______________________________

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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

___ Lab/Radiology Reports

___ Office Visits

___ Pathology Reports

___ Operative Reports From ______________ To ______________

___ Hospital Reports From ______________ To ______________

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: ______________________