OBSTETRICS AND GYNECOLOGY OF NORTH TEXAS, L.L.P.
1600 W. College, Suite 540, Grapevine, TX 76051
(817) 481-5863 (817) 416-5323 Fax

OFFICE USE ONLY
PATIENT ID#: __________________
DATE RECEIVED: __________________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME ____
LAST FIRST MI

DATE OF BIRTH: ______-______-______ OTHER NAME(S) USED: ___________________________

USE THIS SECTION IF YOU WOULD LIKE OUR OFFICE TO REQUEST YOUR RECORDS FROM ANOTHER OFFICE

☐ I HEREBY AUTHORIZE ____
NAME OF DOCTOR, CLINIC OR HOSPITAL

_______________________________________ _______________________________________
ADDRESS PHONE

_______________________________________ _______________________________________
CITY, STATE, ZIP FAX

TO RELEASE MY HEALTH INFORMATION TO OBSTETRICS AND GYNECOLOGY OF NORTH TEXAS (PLEASE CIRCLE ONE)

Dr. Robert Wai * Dr. Julia Flowers * Dr. Carrie Morris * Dr. Sofia Lieser * Dr. Georgia Blair

USE THIS SECTION IF YOU WOULD LIKE YOUR RECORDS SENT TO ANOTHER DOCTOR

☐ I HEREBY AUTHORIZE ***OBSTETRICS AND GYNECOLOGY OF NORTH TEXAS*** TO RELEASE MY HEALTH INFORMATION TO:

NAME: ____
NAME OF PERSON, FACILITY OR AGENCY TO WHICH THE INFORMATION SHOULD BE RELEASED

_______________________________________ _______________________________________
ADDRESS PHONE

_______________________________________ _______________________________________
CITY, STATE, ZIP FAX

____
EMAIL

*****HEALTH INFORMATION TO BE RELEASED*****

I specifically authorize release of the following information:

	DESCRIPTION	DATE(S)
☐ Entire Medical Record	____________	____________
☐ History/Physical Exam	____________	____________
☐ Progress Notes	____________	____________
☐ Lab Report	____________	____________
☐ X-ray/Ultrasound Reports	____________	____________
☐ Other	____________	____________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information with the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to the information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to ensure treatment. I understand that I may inspect or copy the information the information to be used or disclosed, a provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If you have questions about disclosure of your health information, I can contact the Medical Records Manager or the Practice Manager at (817) 481-5863.

_______________________________________ _______________________
Signature of Patient or Legal Representative Date

_______________________________________ _______________________
Relationship to Patient (If Legal Representative) Witness