Gynics Associates

GYNECOLOGY • OBSTETRICS

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Authorization for Release of Medical Records

Patient Name _____ Date of Birth_____
Address _____ SSN _____
City _____ ST _____ ZIP_____ Phone # _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below. I understand this information will be provided within **15 business days** from receipt of request and that **a fee for preparing/furnishing this information may be charged** according to rulings set forth by the Texas State Board of Medical Examiners**.**

Please provide Name of Doctor/Organization, Address, Phone and **Fax numbers**

Send records to:

_____
_____
_____
_____

Release Records from:

_____
_____
_____
_____

Information to be released: (please check all that apply)

___ Visit/Progress notes ___ Laboratory test results ___ Pap Smear
___ Obstetrical records ___ Operative reports ___ Pathology reports
___ Radiology/Imaging reports
___ Other, Please describe:_____

_____ I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug(substance) abuse or any such related information.
Initial

Dates to include: Please check one. We will use today's date to determine the last month of service.

___ Most recent ___ Last Year ___ Last 3 Years ___ All ******$25 fee if more than 3 yrs***
___ Other, please describe:_____

Purpose for this release:

___ Continuing Care ___ 2nd Opinion ___ Personal use ___ Social Security/Disability
___ Consult/referral ___ Insurance ___ Legal purposes ___ Leaving Gynics Associates
___ Other, Please describe: _____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Gynics Associates has specific fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until_____ (date or event).

I understand I may revoke this authorization at any time by notifying the Custodian of Medical Records at Gynics Associates. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Legal Representative Today's Date

_____ _____
Relationship to Patient Legal Authority (attach supporting documentation)