Hill Country OB/GYN Associates

Authorization for Release of Information

In accordance with legal and regulatory agency requirements, the health record is the property of Hill Country OB/GYN Associates. A fee of $25.00 is charged for the first 20 pages then $0.50 per page thereafter, not to exceed $15.00. A fee is only assessed when records are released directly to the patient. There is no fee for records sent directly to a physician or medical facility.

Patient Information:

*Patient Name:*_____*DOB*_____/_____/_____

*Last four digits of your Social Security #:****-**-_____

Release Records to:

Hill Country OBGYN Associates Myself for Personal Use

_____

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Physician or Medical Facility Name: _____
Phone Number: _____
Fax Number: _____
Address: _____
_____

Please Release the Following:

_____ Most recent office visit /test results
(Date Range___/___/___ to ___/___/___)
_____ Specific_____
_____ Lab results
_____ Ultrasound /X-ray reports Year_____
_____ Mammogram results Year_____
_____ Pap smear results Year_____
_____ Medication record
_____ HIV
_____ Entire Record

_____ OB Records ___current pregnancy ___Previous pregnancy /delivered ___/___/___

****A date range must be provided. If not indicated, only the last date of service will be sent.****

Purpose or Need for Disclosure:

_____ Transferring Care
_____ Disability Determination
_____ Other_____
_____Attorney/legal
_____Insurance
_____ Primary Care Physician
_____ Midwife
___ (current pregnancy only)

I understand that: The information released is for the specific purpose stated above. I **will not** hold Hill Country OB/GYN Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I also understand that my medical records may contain reports that only a physician can interpret. I may revoke this authorization at any time by notifying Hill Country OBGYN. 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 of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient Signature: _____ **Date of Request:** _____

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