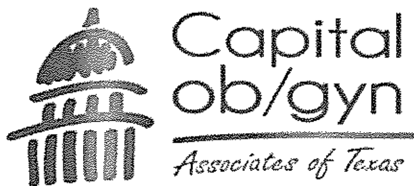

12201 Renfert Way Suite 325, Austin, Texas 78758
Phone (512)836-2536 Fax (512)284-8063

Authorization for Release of Medical Records

Patients Full Name: ______________________ Any other Name: ______________

DOB: _____/_____/_____ Phone #:( )______-________ Last year seen: _________

( ) Records Requested From: | **( ) Send Records To:**

( ) Records Requested From	( ) Send Records To
Physician's Name	Physician's Name
Address	Address
City/State/Zip	City/State/Zip
(FAX including Area Code) Phone Number	(FAX including Area Code) Phone Number

Information Being Requested:
( ) Recent Labs & Notes ( ) Last Lab Report ( ) Entire Medical Record
( ) Other (SPECIFY): ____

Reason or Purpose For Release: ( ) Mutual Patient ( ) Insurance ( ) Changing Physicians
( ) Other: ____

By signing below, I understand that according to the rules set by the Texas State Board of Medical Examiners, Capital Ob/Gyn has 15 business days from the date this request was received, to provide me with an exact copy of the above requested information within my medical record. ***I am also aware that a fee may apply to this request which may be the patient's responsibility.***

***I understand that these records may include information on sexually transmitted disease, AIDS, HIV, mental health, alcohol/drug abuse.

( )YES, I authorize the release of this information ( )NO, I do not authorize the release of this information.

***If I have questions about the release of my information, I understand that I may contact the office of Capital Ob/Gyn.

Patient Signature: ______________________________ **Date:** ______________

In case of infertility treatment, my husband/partner agrees, by signing below, to the release of any information pertaining to him.

Husband/Partner Signature: ______________________________ Date: ______________