Capital ob/gyn
Associates of Texas
12201 Renfert Way, Suite 220 Austin, Texas 78758
P (512)836-2536 F (512)284-8063

Authorization for Release of Medical Records

Patient's Full Name: _____

DOB: _____ Phone#: _____ Last year seen: _____

Records Requested From:	Send Records To:
_____ Physician's Name	_____ Physician's Name
_____ Address	_____ Address
_____ City/State/Zip	_____ City/State/Zip
_____ FAX (Including area code)	_____ FAX (Including area code)

Information Being Requested:

_____ Recent Labs & Notes _____ Last Lab Report _____ Entire Medical Record

_____ Other (please specify) _____

Reason or Purpose for Release: ____ Mutual Patient ____ Insurance ____ Changing Physician

_____ Other (please specify) _____

By signing below, I understand that according 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 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 to him

Husband/Partner _____ Date: _____