

BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

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#17 PROFESSIONAL PARK
WEBSTER, TX 77598
TELEPHONE (281) 332-9511
FAX (281) 332-6685

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone #: _____

I hereby authorize Bay Area Obstetrics & Gynecology, PA and its representative to disclose health information about me to the following individual or organization:

Recipient Name: _____ Telephone #: _____

Address: _____

For the purpose of: _____ Continued Care _____ Research
_____ Personal _____ Legal
_____ Insurance _____ Other (please specify)
_____ Disability _____

Please release the following:

- _____ Entire Record
- _____ Progress Notes
- _____ Laboratory Results
- _____ Ultrasound Reports
- _____ Other Diagnostic Reports (specify) _____
- _____ Other (specify) _____

Dates of Service Needed:

- _____ All
- _____ Last visit only
- _____ Records from (date) _____ to (date) _____

I am aware that such records may contain information related to behavioral or mental health, substance abuse (both alcohol and drug) and sexually transmitted diseases (including test results related HIV/AIDS), and specifically authorize the release of such information pursuant to this authorization.

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under 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.

I understand I am under no obligation to sign this authorization and that my ability to obtain services from Bay Area OB-GYN will not depend in any way on whether I sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided by state and federal laws.

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact Cindy Flynn or Reata Baker.

By signing below, I authorize Bay Area OB-GYN and its representative to release the information about me described above.

Signature of Patient

Date

Relationship to Patient
(if Legal Representative)

Witness

**COMPLETE ONLY IF INFORMATION IS TO BE RELEASED
DIRECTLY TO PATIENT:**

I understand that my medical record may contain reports; test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent any misunderstanding of the information contained in these entries. I will not hold my doctor with Bay Area OB-GYN liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient

Date

Signature of Patient
(if Legal Representative)

Witness

Date request completed _____ #pages copied _____ Reviewed only _____
Charges\$ _____ Cash _____ Check _____ Records copies by(initials) _____

recordsrelease