Authorization to Release Medical Records

I, __________________________ D.O.B. _________ who resides at ______________________
in the city of________________________ in the state of ________hereby authorize:

Provider's Name: ________________________
Address: Lone Star OB/GYN Associates
7950 Floyd Curl Dr. Suite 300/400
San Antonio, TX 78229-3916
Phone: 210-615-6505 Fax: 210-615-1321

To disclose the following specific medical information by _____ fax or _____ mail to:

Physician's Name: ____
Address: ____
Phone: ___________________________ Fax: ________________________________

To disclose the following specific medical information by _____ fax or _____ mail to:

Reason for transferring records: ____

My authorization extends only to those data elements/documents initialed below:

____ Records of All Visits ____ Labs ____ Sono or Sono Reports_____ Copies of any Medical Records
____ Other (Must be Specific): ________________________________

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the fate it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Lone Star OB/GYN Associates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

-- ___________ _________________
PATIENT'S NAME PRINTED D.O.B. DATE

______________________________ ______________________________
Patient Signature SSN (If minor or Guardian)