LONE STAR OB/GYN

Authorization to Release Medical Records

I, _____D.O.B. _____ who resides at _____
in the city of _____, in the state of _____ hereby authorize:

Physician's Name:_____
Address:_____
Phone: _____ Fax: _____

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

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

For the purpose of: _____

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'S SIGNATURE/OR GUARDIAN IF A MINOR **SSN (FOR IDENTIFICATION PURPOSES ONLY)**

_____ _____ _____/_____/_____
PATIENT'S REPRESENTATIVE **D.O.B** **DATE**

_____ _____
PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT **WITNESS**