Lone Star OB/GYN Associates 7950 Floyd Curl Drive, Suite 300 San Antonio, TX 78229

Request for Patient Access to Their PHI

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

I _____ am requesting a copy of my medical records be provided to me.
I am aware there is a $6.50 processing fee due prior to completion of this form.

Please select which specific records you are requesting from below:

From (Date): _____To (Date) _____

____Complete Health Records (ALL)
____Medication List
____Progress Notes
____Operative Reports
____Imaging Reports
____Laboratory Reports
Other: _____

How you would like the requested records be provided to you?
Please select only **ONE** of the following.

_____ Pick up in office
_____Mail
_____Fax (please provide fax #)_____
_____Email

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 SIGNATURE/OR GUARDIAN IF A MINOR DATE