OMEGA OB•GYN

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION, PLEASE COMPLETE AND SIGN BELOW.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

Patient Name:_____ Patient's Date of Birth:_____ Patient's SSN:_____

Patient's Address: _____
_____

Patient's Phone Number:_____ Medical Record#_____

Information Requested, including Dates of Treatment, if Applicable:

_____

_____

I understand that the information in my health record may include information, relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
____Yes, I consent to the release of this information. ____No, I do not consent to the release of this information

Purpose of Release:

_____

The Information Is Being Requested From:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

The Information Is To Be Provided To:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

1. I understand that this authorization will **expire** on *(insert date)*_____.
2. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Omega Ob-Gyn in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

THE PATIENT HAS THE RIGHT TO RECEIVE A COPY OF THIS FORM.
Under HIPAA, with patients' written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law, with patients' written request, records must be provided within 15 days of a request.