

Obstetrics & Gynecology Associates

Patient Name: _____ Date of Birth: _____

Reason for Request (must be completed): _____

This letter will authorize Obstetrics & Gynecology Associates, Dr. _____ to:

_____ **Release Records**

_____ **Obtain Records**

from any listed provider or facility a copy, summary or narrative of my medical records as indicated (as) by the check mark(s) below or to otherwise release confidential information. At this time I am requesting the following:

- Complete record
 Records of care from _____ to _____ only
 Records of care concerning the following condition(s) _____
 Other(Specify): _____

Name of Physician/Medical Facility: _____

Address: _____

Phone: _____ Fax: _____

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 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

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to 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 that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

I understand you will provide this information within 15 business days from receipt of this request and you charge a fee for preparing and furnishing this information.

In accordance with Texas law, the fee for preparing and furnishing medical records is as follows:

Electronic: \$25.00 for the first 500 pages and \$50.00 for over 500 pages.

Paper: \$25.00 for the first 20 pages and .50 per page for each page thereafter plus the cost of postage.

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

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