AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ____ , authorize
(Patient Name)

____, whose address is
(Releasing Physician/Facility)

____
(Street/City/State/Zip)

To release information from the medical record of:

____________________________	_____________________	_____________________
Patient Name	Date of Birth	Social Security Number
____________________________	_____________________	_____________________
Address	City/State/Zip	Phone

To: Medical Records Dept.
Hays Women's Health **phone: 512-268-0286**
1180 Seton Parkway, Suite 240 **fax: 512-268-0386**
Kyle, TX 78640

Dates Requested: From: _______________ To: _______________

Information to be released: (Reports may include information on drug/alcohol/psychological/HIV or communicable disease treatment)

Circle all that apply:

History & Physical HIV/AIDS Laboratory EKG Consultations

Progress Notes Radiology/MRI/CT Other: ______________________________

Purpose of Release:

Personal Use Legal Purposes Insurance Continuing Medical Care

Social Security/Disability Other: ______________________________

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

_______________________________________ _______________________________________
Signature of Patient Signature of Parent/Executor/Legal Representative

_______________________________________ _______________________________________
Date Date