SOUTHQB AUSTINGYN PFLUGERQB VILLEGYN RIVERQB PLACEGYN

# Medical Record Release

Printed Name: Date of Birth

Address: SSN:

Phone#:

**Information to be Released – Covering the Following Periods of Health Care**

From date: To date:

**Please check type of information to be released:**

- ☐ Entire Medical Records
- ☐ Consultation Reports
- ☐ Laboratory Test Results Reports
- ☐ Other (Specify)
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Radiology Reports

**Purpose of Request:**

☐ Treatment or Consultation ☐ At the Request of the Patient ☐ Continuing Care

**Person Authorized to Release Information:**

**Name:** _____

**Phone/Fax#:** _____

**Attention:** _____

**Person Receiving Medical Records:**

**Name:** **Riverplace OBGYN**

**Fax#:** **844-971-6110**

**Phone#:** **512-473-8300**

**Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:**

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care and/or, sexually transmitted disease, Hepatitis B or C and/or other sensitive information, I agree to its release ( ) YES ( ) NO_____(Initials)

I understand that I my medical or billing record contains information in reference to HIV/AIDS testing and/or treatment I agree to its release ( ) YES ( ) NO_____(Initials)

**Time Limit & Right to Revoke Authorization:**

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 6611 Riverplace Blvd. Ste. 202, Austin, TX 78730.

Unless revoked, this authorization will expire on the following date or event _____. If no expiration is set forth, this authorization will expire 180 days from date of signature.

**Re-disclosure:**

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This facility, it's employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Signature of Patient or Personal Representative Who May Request Disclosure:**

I understand that I may not condition my treatment on whether I sign this authorization form unless specified above under "Purpose of Request". I can inspect or copy the protected health information to be used or disclosed. I authorize ATX OBGYN Family of Clinics to use and disclose the protected health information specified above.

Signature_____Date_____

Authority to Sign if not the Patient:_____