

Authorization to Release Medical Records

Patient Name: _____ **DOB:** _____

I authorize the release of medical records as specified below:

FROM: Name: _____

Address: _____

City, State, Zip: _____

Phone, Fax: _____

TO: Name: _____

Address: _____

City, State, Zip: _____

Phone, Fax: _____

****Reason for release:** _____

Please release the following:

_____ Complete medical records

_____ Lab reports

_____ Pap results

_____ Progress notes

_____ Imaging reports

_____ Op reports

*** I understand that this information may include information on sexually transmitted disease, AIDS, HIV, mental health, alcohol/drug abuse.

_____ **YES**, I authorize the release of this information _____ **No**, I do not authorize 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 patient's written consent is prohibited.

I understand that I have the right to revoke this authorization (in writing) at any time. The revocation will not apply to information already released in response to this authorization. A revocation will NOT apply to my insurance company when law provides my insurer with the right to contest a claim under my policy.

This authorization is valid for **6 months from the date below** unless otherwise specified _____

TRANSFERS FROM OUR OFFICE REQUIRE A MEDICAL RECORDS FEE. I understand that Cedar Park Gynecology, the office of Jonathan B. Buten, MD, follows the Texas State Board of Medical Examiners regulations to approve an initial fee of \$25.00 for the first 25 pages of a record and \$.15 for any additional pages. This fee is due prior to the request being completed. After payment is received, records can be expected by the end of 15 business days.

If I have questions about release of my information, I understand that I may contact the Privacy Officer.

Signature of patient or authorized representative

Date

Relationship to patient

Witness