3900 Junius Street Ste 145
Dallas TX 75246
Phone 214-377-1699
Fax 214-824-8365

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

1. PATIENT INFORMATION

PATIENT NAME: _____DATE OF BIRTH: ____/____/____

PATIENT ADDRESS: _____
STREET CITY STATE ZIP

PATIENT HOME PHONE: _____ PATIENT EMAIL: _____

2. RECIPIENT AUTHORIZATION

I_____ hereby authorize _____

(Phone: _____Fax #: _____) to release a copy of my medical records to Magnolia Obstetrics and Gynecology.

3. INFORMATION TO BE RELEASED

- ☐ Entire Medical Record_____
- ☐ Visit Notes_____
- ☐ Pathology Reports_____
- ☐ Lab Reports_____
- ☐ X-ray Reports_____
- ☐ Other (specify)_____

3. PURPOSE OF INFORMATION RELEASE

- ☐ Further medical care
- ☐ Payment of insurance claim
- ☐ Legal investigation
- ☐ Applying for insurance
- ☐ Disability Determination
- ☐ Vocational Rehab, evaluation
- ☐ At the request of the individual
- ☐ Other (specify)

4. INCLUSION OF PRIVILEGED INFORMATION

I understand that if my record contains information concerning alcohol or drug abuse/treatment, information concerning abortion, HIV testing and related information, AIDS-related conditions, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information is included in this disclosure.

5. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization at any time, except to the extent that the individual or entity that is to make the disclosure has already completed action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient to other individuals or organizations that are not subject to privacy protection laws.
- I understand that I may see/obtain a copy of the information described on this form, for a reasonable copy fee, per my request.
- **This authorization will automatically expire one year from the date signed.**

SIGNATURE OF PATIENT_____DATE: _____

RELATIONSHIP TO PATIENT_____