Hill Country OB/GYN Associates
9805 Brodie Lane, Austin, TX 78748
Office: (512) 462-1936 Fax: (833) 448-3184

Authorization for Request of Information To Hill Country OB/GYN Associates

****Form must be complete in order to be processed****

Patient Information:

Patient Name: _____ DOB: _____

Request Records From:

Physician or Medical Facility Name: _____
Phone Number: _____
Fax Number: _____
Address: _____

Release Records To Hill Country OB/GYN Associates:

☐ Ana Eduardo ☐ Margaret Landwermeyer ☐ Lisa Schneider ☐ Chris Hart
☐ Melissa Quinn ☐ Amanda DiSarro ☐ Lauren Cooper ☐ Kayle Sessions

Please Release the Following:

☐ Most recent office visit /test results
☐ Entire Record
☐ Current pregnancy
☐ OB Records
☐ Lab results
☐ US/ Xrays
☐ Medication record
☐ HIV
☐ Date Range _____ to _____
☐ Pap Smear results Year _____
☐ Mammogram results Year _____
☐ Previous pregnancy/delivered _____
☐ Specific:

I understand that: The information released is for the specific purpose stated above. I will not hold Hill Country OB/GYN Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I also understand that my medical records may contain reports that only a physician can interpret. I may revoke this authorization at any time by notifying Hill Country OBGYN. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. I further understand that I will not be able to make appointments or seek medical advice from Hill Country OBGYN two weeks after my medical records have been sent.

***NOTICE**: This Authorization is valid for 180 unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department Hill Country OB/GYN Associates, except to the extent that Hill Country OB/GYN Associates has already completed action on it.*

Patient Signature: _____ **Date Requested:** _____

Appointment Date & Time: _____