



Hill Country OB/GYN Associates

Authorization for Release of Information

In accordance with legal and regulatory agency requirements, the health record is the property of Hill Country OB/GYN Associates. A fee of \$25.00 is charged for the first 20 pages then \$0.50 per page thereafter, not to exceed \$15.00. A fee is only assessed when records are released directly to the patient. There is no fee for records sent directly to a physician or medical facility.

Patient Information:

Patient Name: _____ DOB ____ / ____ / ____ Last four digits of your Social Security #: ***-**-_____
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Release Records to:

Hill Country OBGYN Associates <hr/> Physician or Medical Facility Name: _____ Phone Number: _____ Fax Number: _____ Address: _____	Myself for Personal Use
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Please Release the Following:

<input type="checkbox"/> Most recent office visit /test results (Date Range ____/____/____ to ____/____/____) <input type="checkbox"/> Specific _____ <input type="checkbox"/> Lab results <input type="checkbox"/> Ultrasound /X-ray reports Year _____	<input type="checkbox"/> Mammogram results Year _____ <input type="checkbox"/> Pap smear results Year _____ <input type="checkbox"/> Medication record <input type="checkbox"/> HIV <input type="checkbox"/> Entire Record
<input type="checkbox"/> OB Records ___current pregnancy ___Previous pregnancy /delivered ____/____/____	
A date range must be provided. If not indicated, only the last date of service will be sent.	

Purpose or Need for Disclosure:

<input type="checkbox"/> Transferring Care <input type="checkbox"/> Disability Determination <input type="checkbox"/> Other _____	<input type="checkbox"/> Attorney/legal <input type="checkbox"/> Insurance	<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Midwife <input type="checkbox"/> (current pregnancy only)
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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.

Patient Signature: _____

Date of Request: _____