AMBER SHAMBURGER, M.D.,
ERIKA ROBERTS, M.D.

ASHLEY
MARCANTEL, M.D JAMIE
GARZA, WHNP

Medical Records Release

(Name of Patient)

(Birthdate)

(Street Address)

(City, State, Zip Code)

I hereby Authorize Friendswood Women to release information from the medical record of:

(Name of Physician)

(Name of Health Care Facility)

(Street Address)

(City, State, Zip Code)

Release of Records to:

(Name of Physician)

(Name of Health Care Facility)

(Street Address City, State, Zip Code)

(Telephone and Fax #)

Information to be Released:

All Clinic Records
Office Notes
Photographs
Immunizations
Imaging/Radiology
Labs
Other (Specify):

List other facilities' records to be included when releasing for the purpose of continuing medical care:

For treatment dates:

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

Mental health
Developmental disabilities
Alcoholism
AIDS test results
AIDS-released disease diagnosis
Drug
Other

Purpose or need for disclosure: (check applicable categories)

Further medical care
Application for insurance
Disability determination
Payment of insurance claim
Vocational rehabilitation evaluation
Other (Specify):
Legal
Personal

I acknowledge, and hereby consent to such, that the release of information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

(Initials)

I understand that this authorization shall be valid for 180 days after the date it is signed unless otherwise stated below or revoked through written notice to Medical Records.

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed above.

I, the undersigned have read the above and authorize staff to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclose by the recipient and may no longer be protected. I hereby release and hold harmless Friendswood Women from all liability and damages resulting from the lawful release of my Protected Health Information.

Signature of Patient/Parent: ______________________ Date: __________

(if signed by person other than patient, state relationship and authorization to do so)