Medical Records Release Form
New Braunfels OB/GYN

Patient's Name:_____Date of Birth:_____

Social Security#:_____Phone#:_____

By signing this form, I authorize:

Doctor:_____

Address:_____

_____

Phone and fax: _____

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 below.

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial:_____Date:_____

Mental Health/Substance Abuse: I consent to the release of any medical records related to treatment for mental health and/or substance abuse with the rest of my medical records.
Initial:_____Date:_____

Records you may release subject to the Release Form are as follows:
__History & Physical __Lab Results __X-Ray_____

__Referral Letters __Office Notes __Other_____

Release my protected health information to the following person(s)/entity:

Doctor:_____

Address:_____

_____

Phone and fax: _____

Patient Signature (or legal representative):

_____Date:_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.