Medical Records Authorization Form

(*Circle One*)		(*Circle One*)	
Release To	Request From	Release To	Request From

Comprehensive OBGYN

Name: _____

Cesar Reyes, MD * Renee Chan, MD

Address: _____

Gerald Luciani, MD * Sean Sadler, DO

Yara Ramirez, MD

Address: _____

City: _____ State _____ Zip _____

1700 N. Lake Forest Dr., McKinney, TX 75071

Phone: _____

Phone (214)733-8001 Fax (972) 542-3559

Fax: _____

The information provided above is *only the patient* if we are sending your records to you directly, otherwise *please list the physician* who currently has your records or is intended to receive your records

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

I authorize the above listed physician/facility/firm/entity and/or its agents/representatives/employees to release, for inspection and copying, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from the dates of _____ to _____. I understand this authorization can be revoked in writing, submitted to the Privacy Official, at any time, until the records have been sent. This authorization will expire in 180 days unless otherwise indicated or revoked: _____.

Initials

I understand this authorization hereby releases the above listed physician / facility / firm / entity and/or its agents / representatives / employees from any legal responsibility or liability for disclosure of the PHI being released to the recipient indicated above. The potential re-disclosure of this information is the responsibility of the aforementioned recipient. The original physician / facility / firm / entity will continue to protect the original record under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand I do not have to sign this authorization to receive treatment and payment for services will not be denied if I do not sign this form unless specified below by the Reason for Requesting Records. I can view or receive a copy of the protected health information to be used or disclosed.

□ Entire Record   □ Progress Notes   □ Lab Reports   □ Pathology Reports   □ MRI/CT/Sono/XRay Reports

□ Operative Notes □ Emergency Room Reports/Records   □ Labor and Delivery Records   □ Other _____

Reason for Requesting Records: _____

_____   Date: _____

Patient/Representative Signature   Printed Name of Representative

_____   Date: _____

Witness Signature   Printed Name of Witness

Special Authorization

I recognize my records pertaining to mental health and HIV/AIDS is protected separately from my general medical records and hereby authorize the release of these records in the same manner the records above are released.

_____ Date: _____

Patient/Representative Signature   Printed Name of Representative