SOUTHEAST TEXAS OB/GYN ASSOCIATES, PA.
755 N 11th Street, Suite P4200 • Beaumont, TX 77702
(409) 899-1499 • Fax (409) 898-0778

Medical Record #

Authorization to Release Medical Information

Patient Name _____ Other Name_____

Birthdate_____

Current Address _____

Daytime Phone # _____Social Security # _____

REASON FOR RECORD
- ❑ Personal
- ❑ Medical Care
- ❑ Benefits
- ❑ Litigation
- ❑ Workman's Comp
- ❑ Other _____

I AUTHORIZE INFORMATION RELEASE *FROM:*

_____
Name of Facility and Physician

_____
Phone Number Fax Number

_____
Address

_____
City, State, Zip

PLEASE SEND MY RECORDS *TO:*

_____
Facility to Receive Information and Physician

_____
Phone Number Fax Number

_____
Address

_____
City, State, Zip

Type of Information to be Released

❑ Specific Information Only Please

_____ PAP Results
_____ Mammogram Reports
_____ Medications /Therapy
_____ Lab
_____ Genetics /Amniocentesis
_____ Immunizations
_____ OB / GYN Records
_____ History and Physical
_____ Operative Report Dates_____
_____ Pathology Report Dates_____
_____ Ultrasound Report Dates_____
_____ Radiology Reports Dates_____

Other _____

❑ General Medical Records (from the past two years only)

Protected or Sensitive Information

Certain information cannot be released without specific authorization. Please initial below **if you agree to release the following:**

_____ *Initials* I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ *Initials* I recognize that the information disclosed may contain MENTAL HEALTH information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ *Initials* I recognize that the information disclosed may contain data regarding HIV/AIDS testing. I specifically consent to disclosure of such information.

_____ *Initials* I recognize that the information disclosed may contain data regarding GENETIC TESTING. I specifically consent to disclosure of such information.

Permission to Fax Information: ❑ Yes ❑ No

_____ *Initials* I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event)_____

THERE MAY BE FEES FOR PROVIDING COPIES.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Patient's Name or Name of Patient's Legal Representative (if applicable) Relationship to Patient

❑ Patient's or Legal Representative's Personal Identification Verified by_____

For Office Use Only: Patient's or Legal Representative's Personal Identification Verified by:_____

Date copied: Date sent via fax/email:_____Initials:_____Processor:_____