Request for release of records to Round Rock OBGYN, PA

Authorization for Release and Disclosure of Protected Health Information

Name of physician, hospital, medical center or lab that you are requesting records from:

Name: ____ Phone#: ____________________

Address: ____ Fax#: ___________________

City/State/Zip: ____

I am requesting that the medical information for the person listed below be transferred to:

Round Rock OBGYN, PA

4112 Links Lane, Suite 205
Round Rock, TX 78664
512-255-7762 phone   866-571-3565 fax

Please release the following information:

____ Problem List
____ Progress Notes
____ History & Physical
____ Other (specify)
____ Lab Reports
____ Medications
____ Radiology Reports
____ All records
____ Immunization Records
____ Specialist Reports
____ OB Records

This information is necessary for the following purpose:

____ Continued Patient Care
____ Insurance
____Personal Use
____Other (specify)
____Attorney/Legal

Name: ____________________________________ Date of Birth: __________________

I understand that the information in my or my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodediciency virus (HIV). It may also include informatin about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____________________________________ ______________________ _______________
Signature Relationship Date