



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

1000 Hesters Crossing, Ste 400

Round Rock, TX 78681

512-255-7762 phone

512-255-7761 fax

Please release the following information:

<input type="checkbox"/> Problem List	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Medications	<input type="checkbox"/> Specialist Reports
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> OB Records
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> All records	

This information is necessary for the following purpose:

<input type="checkbox"/> Continued Patient Care	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Attorney/Legal
<input type="checkbox"/> Insurance	<input type="checkbox"/> Other (specify)	

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 immunodeficiency virus (HIV). It may also include informatin about behavioral or mental health services, and treatment for alcohol and drug abuse.

Signature

Relationship

Date