Health Central Women's Care, P.A.
Obstetrics, Gynecology and Infertility

Medical Records Release Form - Walnut Hill office – Drs. Staub, Griffith, Chapman, Woodbridge, Tillman, Light

Office phone ***214-365-1150*** *Office fax* ***214-363-2477*** ***A nominal fee may be assessed for copies of records.***
By signing this form, I authorize Health Central Women's Care, P.A. 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 physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Date(s) of Service: _____ Social Security Number: _____

The information you may release subject to this signed release form is as follows:

❑Complete Records ❑History & Physical ❑Progress Notes ❑Care Plan
❑Lab/Pathology Reports ❑Consultation Reports ❑Discharge/Death Summary ❑Treatment Record
❑Operative Reports ❑Hospital Reports ❑Medication Record ❑Other_____

Release my protected health information to the following physician/person/facility/entity:

Name: _____Phone:_____

Address:_____Fax:_____

City:_____ State:_____ Zip Code:_____

The purpose/reason for this release of information is as follows:

❑Permanent Transfer ❑Personal Copy ❑Legal ❑Insurance Application
❑Other (please describe) _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and /or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. 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 the authorization. I understand I may be charged a reasonable fee for copies of my medical records in accordance with Section 165.2 of the Texas Administrative Code.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows:

Signature:

_____ _____
Patient or Legally Authorized Representative Printed Name of Patient or Legally Authorized Representative

_____ _____
Relationship to Patient Date