2450 Fondren, Suite 275 Houston, Texas 77063 · Ph: 713-339-1000 Fax: 713-339-1003

MEDICAL RECORDS RELEASE FORM

I, _____, hereby authorize the party below, to release information from my health record ***to Piney Point Women's Center, PLLC***:

Doctor/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

For the purpose of: (please check one)

☐Continued Treatment ☐Legal Review ☐Insurance purpose ☐Personal review of information ☐Other

I limit the information to be released to the following items:

☐Discharge Summary ☐Consultation ☐Pathology Report ☐Operative Note
☐Diagnostic test (e.g. Lab, X-ray, Radiology)(please specify)
☐Medical Visits ☐Other (please specify) _____

Covering records from on or about (Date) _____ to (Date) _____

If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

☐ I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

☐ I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV

infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

I understand that this authorization is valid for a one year period from date it is signed or sooner if specified below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department.

I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

Patient Name (PLEASE PRINT) Patient Date of Birth

_____ _____

Signature of Patient/ Representative/ or Legal Guardian) (Date) Date

Expiration Date _____ (If less than one year)

*Under HIPAA you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.