Austin Springs Women's Health

MEDICAL RECORDS NOTIFICATION

Patient Name:	Date of Birth:

Information to be Release-Covering the following periods of healthcare.

From Date: _____ To Date: _____

Information requested to be released:	Purpose of request:
☐ Entire Medical Records ☐ Pathology/Lab Reports ☐ Radiology Reports ☐ Consultation/Progress Notes ☐ Last ____ year(s) of Medical Records ☐ EKG/Chest X-rays ☐ Other: _____ ☐ Billing Records	☐ Continuing Care ☐ At the request of the patient ☐ Second opinion ☐ Rendering Provider ☐ Transfer of Care ☐ Other: _____

Authorized to **Release** Information:	Authorized to **Receive** Information:
Phone:	Phone:
Fax:	Fax:
Contact Person:	Contact Person:

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse, psychiatric care and/or sexually transmitted information. I agree to release the information to the authorized facility/provider or person(s). _____.

Time Limit & Right to Revoke Authorization:

Except to the extent that action has been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the Facility Privacy Officer: **1221 W BEN WHITE BLVD. STE 210A AUSTIN, TX 7804**. Unless revoked, this authorization will expire on the following date or event_____. If no expiration date is set form, this authorization will **expire 1 year** from date of signature.

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This facility, its employees, officers, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated any authorized herein.

Signature of Patient or Personal Representative who may have requested the disclosure.

I understand that I may not condition my treatment on whether I sign this authorization from unless specified above under "Purpose or Request". I can inspect or copy the protected health information to be used or disclosed. I authorized **Austin Springs Women's Health**, its providers, staff, and any affiliated clinics to use and disclose protected health information specified above.

Authorized Signature to Request Records:	
Authority to sign if not the patient:	
Date of Request:	