AUTHORIZATION FOR USE AND DICLOSURE OF PROCTECTED HEALTH INFORMATION

In accordance with legal and regulatory requirements, the health record is the property of Cornerstone OBGYN.

Patient Information: (Please Print)

Patient Name: _____ Date of Birth: _____

Last four digits of Social Security#: ***-**-_____ Today's Date: _____

Please Circle "To" or "From":

TO or FROM: Cornerstone OBGYN
16040 Park Valley Drive, Ste 222
Round Rock, Texas 78681
Ph: 512-341-8001 Fax: 512-341-8011

TO or FROM: (Medical Facility or Physician) _____
_____
Address: _____
City/State/Zip: _____
Phone No ( )_____ Fax No: _____

____Dr. Choudhry ___Dr. Anger ____ Dr. Duncan ____ Dr. Bookout

Please Release the Following:

_____ Most recent office visit/test results _____Lab Results _____Mammogram Results
(Date Range ____/____/____ to__ __/____/_____) _____Ultrasound _____ Entire Record

_____OB records _____Current pregnancy Other: (please specify)_____

****A date range must be provided. If not indicated, only the last date of service will be sent. ****

Reason for Release: (Article 449b, Sec.5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reason or purpose for the release")

_____Transferring Care (reason): _____
_____ Primary Care Physician _____ Consultation with another Physician _____ Midwife
_____ Personal Record _____ Other (please specify)_____

_____ (Initial) **I understand that this form must be completed in its entirety to be considered valid, and our office will not accept an incomplete form and it will be null and void.**

_____ (Initial) **I understand there is a minimum charge of $25.00, according to TMA guidelines and this request will be processed upon receipt of that payment. You may go to our website, www.cornerstone-obgyn.com, to make your payment online, or you mail a check/money order to our office.**

_____ (Initial) I understand that in accordance with TMA guidelines this process may take up to fifteen (**15**) business days to process.

_____ (Initial) I consent to the release of any positive or negative test results for HIV/AIDS infection, antibodies to AIDS or infection with any other causation agent of AIDS with the rest of my medical record.

_____ (Initial) I understand that the information released is for the specific purpose stated above, and **will not** hold Cornerstone OBGYN liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ (Initial) I may revoke this authorization at any time, in writing to Cornerstone OBGYN. Unless revoked, the automatic expiration date will be thirty (**30**) days from date of signature.

_____ (Initial) I understand that 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 Accountability Act of 1995. This facility, its employees, officers and physicians are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Patient/Legal Guardian Signature Date