



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED 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 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) _____

Please disclose the above information FROM:

Send TO:

Name/Entity: _____

Name/Entity: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Email: _____

I understand the risk that this will come from an email that is not encrypted.

____ (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 may be a charge for these medical records 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 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 hereby 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