Medical Records Release Form from another provider

(To be used to provide us with your records from another provider)

Patient Name: _________________________________ Soc. Sec. # ___________________

Address: ______________________________________ Date of Birth: ___________________

By signing this authorization, I authorize ____
to use and/or disclose certain protected health information (PHI) about me. I authorize you 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 person(s) or entity listed below by mail.

Please send my protected health information to the following location:

Northlake Obstetrics & Gynecology, P.A. – (select one).

6124 W. Parker Rd	**7777 Forest Lane**	**5757 Warren Parkway**
MOB 3, Suite 136	**C-234**	**Suite 200**
Plano, TX 75093	**Dallas, TX 75230**	**Frisco, TX 75034**
Phone: 972-981-7711	**Ph: 972-566-7711**	**Ph: 214-618-7100**

The information will be used or disclosed for the following purpose:

____

My authorization extends or is limited to:
___ Records of my visits from 2007 to present unless otherwise specified.
___ Patient history
___ Progress notes
___ Diagnostic reports
___ Consultation reports
___ Statement of charges and payments
___ All of the above
___Other: must specify ____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released.
4. Treatment, payment and operation of our business may not be conditioned upon this authorization.
5. The release of information authorized may be subject to re-disclosure by the recipient.

This authorization will expire on________________________________

____ __________________
Patient Signature [or parent, guardian or legal representative]: Date

MedicalRecordsToUs