Austin Maternal-Fetal Medicine

Authorization For Use or Disclosure of Medical Record Information
Austin Maternal-Fetal Medicine

sharecare

TX10902

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

Email Address: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize Austin Maternal-Fetal Medicine to release my medical record information to:

☐ Mail Copies To: ☐ Discuss Medical Information With:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ◯Personal ◯Continuing Care ◯Insurance ◯ Legal ◯Transfer (*Explain*) ◯ Other (*Explain*)

Comments/ Authorization Specifications: _____

NOTICE: The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to federal and/or state privacy laws. Austin Maternal-Fetal Medicine will not condition treatment on the signing of this Authorization or payment of associated fees.

Information to be Released

◯ Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics)

◯ Please provide my entire medical record for dates: From_____To_____

◯ Please provide my entire billing record for dates: From_____To_____

◯ Please provide *only* the following records within the date range listed below:

___ Progress Notes/Consults ___ Labs ___ Radiology Reports
___ Pathology ___ Billing ___ Other (*Explain Below*)

From _____ To _____

Comments/ Authorization Specifications: _____

NOTICE: This Authorization is valid for 365 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department at Austin-Maternal Fetal Medicine, except to the extent that Austin Maternal-Fetal Medicine has already completed action on it.

POTENTIAL FEES: See the "Fee and Process Explanation Letter" for more information regarding associated costs.

Authorization to Release Protected Information

Required: Please complete the check boxes below indicating how protected information should be handled, even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one — *Initial each line below to confirm your choices*

I ☐ **DO** ☐ **DO NOT** want ***Psychotherapy Notes** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

STOP AND REVIEW: Please confirm that you have put a checkmark and initialed **ALL** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure, by the recipient, of any alcohol or substance abuse records released under this Authorization, unless the recipient has received written consent from the person to whom It pertains or as otherwi se permitted by 42 CFR Part 2.

Sign Here Date Here

Patient's Signature **Date**

Parent/Legally Recognized Representative Signature **Date**

Description and Proof of Authority to Act on Patient's Behalf

Know Your Privacy Rights
Refer to the HIPAA **"PRIVACY NOTICE"**

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