Authorization for Release of Medical Records

TO Texas Obstetrics & Gynecology Associates, PLLC
Dr. George B. Branning

Patient Name:

_____

Address:

_____

DOB: ____/____/____ Social Security Number: _____

This is my written authorization for:

Texas Obstetrics & Gynecology, PLLC
[ ] 5757 Warren Parkway Suite 310
Frisco, TX 75034
P: 214-824-2547 F. 214-618-8038

To OBTAIN Information From:

The Office of Dr:

_____

Address:

_____

City: _____ State: _____Zip: _____

Phone Number: _____Fax Number: _____

Release Format: ( ) To Mail ( ) To Fax ( ) To Pick Up on_____

Information to be Released:

( ) All Medical Records ( ) Prenatal Records ( ) Demographics
( ) Lab Reports ( ) X-Ray/Ultrasound ( ) Insurance
( ) Dr Notes ( ) Hospital ( ) Other: _____

Purpose of Disclosure:

( ) Changing Physicians ( ) Insurance Claim ( ) Moving
( ) Legal ( ) Referral ( ) Other: _____

I understand that these records may include information on sexually transmitted diseases, AIDS, HIV, mental, health, alcohol/drug abuse.

( ) **YES**, I authorize the release of this information. ( ) **NO**, I do not authorize the release of this information.

REVOCATION: I understand this authorization may be revoked in writing at any time. Unless otherwise indicated, this authorization will expire 90 days from the date of signature. The physician and the employees are released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian: _____

Date: _____

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FROM Texas Obstetrics & Gynecology Associates, PLLC

Dr. George B. Branning

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