VIOLET CROWN OBGYN

Violet Crown OBGYN - Medical Records Release Authorization

Recipient: (who/where are the records going)

Violet Crown OBGYN
Person/Company

12201 Renfert Way Suite # 305
Address

Austin | Texas | 78758
City | State | Zip

512-580-4766 | 833-464-4278
Phone | Fax

From Clinic/Hospital: (Where are the records coming from)

Austin Area OBGYN Fax 512-450-1146

Patient: _____
Patient Name | Phone /Email | Date of Birth

Dates of Service (Check One and Complete Dates of Service if Required)

☐ Please provide a complete copy of my file for all dates of service

☐ Please provide a complete copy of my file for service from _____ through _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

☑ All Medical Records	☐ History & Physical	☐ Consultation Reports
☐ Emergency Room Record	☐ Operative Report	☐ Discharge Summary
☐ Lab/Pathology Reports	☐ Radiology Reports	☐ Images
☐ Itemized Billing	☐ Other	

Purpose for Disclosure

☐ Disability	☐ Insurance	☐ Attorney
☐ Referring Physician	☑ Patient Request	☐ Other (please state reason)

Other _____

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization(45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time. By signing this I understand the process could take from 7-10 business days to complete.

Please have your medical records sent to Fax No. 833-464-4278

Send completed forms to medicalrecords@aaobgyn.com. To check status, please call (800) 659-4035 or email status@healthmark-group.com

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative