

Authorization to Release Medical Records
Lone Star OB/GYN Associates

I, _____ D.O.B. _____ who resides at _____
in the city of _____, in the state of _____ hereby authorize:

Physician's Name: _____

Address: _____

Phone: _____ Fax: _____

To disclose the following specific medical information by _____ fax or _____ mail TO:
****** If More Than 25 Pages Please MAIL Records, Thank You******

Physician's Names: _____

Lone Star OB/GYN Associates/ Medical Center Tower I
7950 FLOYD CURL #300 SAN ANTONIO, TX 78229
OFFICE 210-615-6505 FAX 210-615-1321

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

____ Records of All Visits ____ Labs ____ Sono or Sono Reports ____ Progress Notes ____ Aids/HIV Information
____ Hepatitis ____ Mental Health and/or Alcohol and Drug Abuse Treatment ____ Copies of any Medical Records
____ Other(Must be Specific): _____

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 otherwise provided by law.
- 2.) A photocopy or fax of this authorization is as valid as this original
- 3.) I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
- 4.) Lone Star OB/GYN Associates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of above information to the extent indicated and authorized herein.
- 5.) Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
- 6.) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

PATIENT'S NAME PRINTED

D.O.B.

____/____/_____
DATE

PATIENT'S SIGNATURE/OR GUARDIAN IF A MINOR

SSN (FOR IDENTIFICATION PURPOSES ONLY)

PATIENT'S REPRESENTATIVE

D.O.B.

____/____/_____
DATE

PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT

WITNESS