

THE OB-GYN PLACE

A PROFESSIONAL ASSOCIATION

JEWELL E. MALICK, D.O. • MAUREEN A. RIBAIL, D.O. • CAROL A. POOLE, M.D.
GYNECOLOGY & PELVIC SURGERY

Authorization to Release Health Care Information

Patient's Name: _____ Social Security #: _____

Previous Name: _____ Date of Birth: _____

Patient's Current Address: _____

Best contact number: _____

I request and authorize The OB-GYN Place, P.A. to release confidential health information by releasing a copy of the medical records of the above named patient to:

Physician/Clinic: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

This request and authorization applies to:

All health care information.

Health care information relating to the following treatment, condition, or dates of treatment: _____

Other: _____

The reasons/purposes for this release of information are: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of Patient or Patient's Authorized Representative

Date Signed

Relationship or status if signed by anyone other than patient: _____
(example: parent, legal guardian, personal representative, etc.)

This authorization expires 180 days after the date it is signed. There is a \$25.00 processing fee.

901 Rockwall Parkway • Rockwall, Texas • 75032 • (972) 772-3234 • Fax (972) 772-3834

www.theobgynplace.com