OBSTETRICAL & GYNECOLOGICAL ASSOCIATES
OF CORPUS CHRISTI
5920 Saratoga, Suite 200
Corpus Christi, TX 78414
(361) 994-5454

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME:_____ DATE OF BIRTH_____

SOCIAL SECURITY NUMBER_____ ACCOUNT NUMBER_____

I AUTHORIZE THE MEDICAL/SURGICAL PRACTICE OF OB-GYN ASSOCIATES OF CORPUS CHRISTI TO:

_____ Send a copy of entire medical record

_____ Send a copy of only the following records/tests listed below:

_____
_____
_____

1. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. This information may be disclosed to and used by the following physician or medical organization:

NAME/ORGANIZATION:_____

Address:_____CITY_____STATE_____ZIP_____

*****Record copies released directly to the patient require a $25.00 fee paid in advance*****
(Fee does not apply to Humana Military or Medicaid patients)

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do it in writing and present my written revocation to the CEO. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or:_____condition. If I fail to specify an authorization date, event or condition, this authorization for this release will expire in 180 days.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclose as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
If Legal Representative Signs, Relationship to Patient **Date**

Patient request to release copy of our records and send to another organization/physician
Electronic copies of records may be requested .