Women's Health Specialists of Dallas, P.A.
8160 Walnut Hill Lane, Suite 200
Dallas, Texas 75231
Phone: 214-363-4421/Fax: 214-987-1657
Web Site: whsdallas.com

HIPAA COMPLIANT AUTHROIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 7-10 business days for copying. There is a fee of $25.00 for medical records given or sent to the patient. The medical records cannot be released until this form is completed and signed by the patient or legal guardian.

You must complete this form thoroughly.

PLEASE PRINT

Step I: Patient Name____ Date of Birth_____________________________

Address____
Street City State Zip Code

Step II: I hereby authorize Women's Health Specialists of Dallas ______to release or to ______obtain my health information.

Name of Physician/Medical Facility____

Address____
Street City State Zip Code Phone# Fax#

Step III: Information to be released: ____
Date (s)/Condition (s)

Your initials are required to release the following information:

______Mental Health Records (excluding psychotherapy notes)

______Genetic Information (including Genetic Test Results)

______Drug, Alcohol, or Substance Abuse Records

______ HIV/AIDS Test Results/Treatment

________ Continuity Care Reason: ____

(***This section must be completed before records will be released)***

________ Transfer of Care

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for 90 days for the release of information as indicated above. **Only records from this facility can legally be released.** Any records from other physicians must be obtained from them.

___________________________________ ______________________________________
Patient Signature & Date Parent/Guardian Signature & Date

___________________________________ ______________________________________
Witness Signature & Date Physician Signature & Date

Date Copied____________________ #Pages Copied________________ Copied By__________________

Signature at Pick Up: ___________________________________ Mailed:___________ Faxed:___________