Vernon & Waldrep OB-Gyn Associates

972-566-4660

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize: **Vernon & Waldrep OB-Gyn Associates**
7777 Forest Lane, Bldg D, Suite 570
Dallas, TX 75230
Phone: 972-566-4660 Fax: 972-566-6413

Circle One **Kathryn Waldrep, MD; Alison Elmquist, MD; Angela Walker, MD; Tara O'Connor, M.D.**
Regan Allen, MD; Allison Kramer Ratner, MD; Chloe Cooper, MD.

To send my medical records to: _____
_____
_____

These records will include the following information as indicated and the information should be released for the following time period: From _____ To _____

___ History and Physical Exam ___ Laboratory Reports ___ MD Progress Notes
___ EKG Reports ___ Non Stress Test Reports ___ Bone Density Reports
___ Mammogram Reports ___ X-Ray/Sonogram Reports ___ Other _____
Specify

(Copies only of the above information will be sent - original reports and photos are not released)
The information is requested for the following reason:
_____ Continuation of Medical Care ; _____ Transfer of Care ; _____ Patients Request
_____ Changing doctors due to: ____ Insurance Change/Network provider; ____ Second Opinion; ____ Moving
____ Personal; _____ Other _____

I am aware that these records may contain information relating to psychological testing or treatment, biofeedback training, alcohol/drug abuse and/or HIV (AIDS) testing results. Such disclosure shall be limited to the following specific types of information: _____
_____

The patient has the right to revoke this consent in writing up to the time that records have been sent. This consent is valid for (60) days from the date of signature. I understand that there may be a fee for preparing this information.

I hereby release Vernon & Waldrep OB-Gyn Associates from any/all legal liability that may arise from the release of this information to the party named above.

Patient's Printed Name: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Patient's Birthdate: _____ Patient's Social Security Number: _____

Home Phone Number: _____ Work Number: _____ Cell Number: _____

To the Party Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

SIGNED: _____ DATE: _____
*(Signature of patient/spouse/parent/guardian/conservator/patient representative)

SIGNED: _____ WITNESS: _____
(If signed by other than patient, indicate relationship)
*Authorized representative must submit copies of legal documentation supporting assignment of this authority.