



A Care Center of Central Texas OB/GYN Associates  
12201 Renfert Way Austin, TX 78758  
(512) 339-6626 Fax (512) 425-3809 records@rwgdocs.com

## Authorization to Release Medical Records

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

**I authorize the release of medical records as specified below:**

**FROM:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone, Fax \_\_\_\_\_

**TO:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phones, Fax \_\_\_\_\_

**\*\*Reason for release:** \_\_\_\_\_

I understand that the information released is for the specific purpose stated above. Any other use of this information without patient's written consent is prohibited.

**Please release the following:**

- Complete medical records
- Lab reports -- Specifics: \_\_\_\_\_
- Progress notes
- Imaging reports -- Specifics: \_\_\_\_\_

\*\*\*I understand that this information may include information on sexually transmitted disease, AIDS, HIV, mental health, alcohol/drug abuse.

\_\_\_\_\_ **YES**, I authorize the release of this information      \_\_\_\_\_ **NO**, I do not authorize the release of this information.

I understand that I have the right to revoke this authorization (in writing) at any time. The revocation will not apply to information already released in response to this authorization. A revocation will NOT apply to my insurance company when law provides my insurer with the right to contest a claim under my policy.

I understand that a reasonable fee for production of medical records shall be a charge of no more than \$25 for the first twenty pages and 50 cents per page for every copy thereafter. Execution of an affidavit is no more than \$15. A separate billing records request may apply at the same time as production of medical records. These fees shall include retrieving, copying, postage and preparation of the records.

This authorization is valid **for 6 months from date below** unless otherwise specified \_\_\_\_/\_\_\_\_/\_\_\_\_.

If I have questions about release of my information, I understand that I may contact the privacy officer for Central Texas OB/GYN Associates.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness