

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Account # _____
Telephone #: _____ D.O.B. _____

INFORMATION TO BE RELEASED TO:

I hereby authorize the following to release the medical information requested, contained in the patient's medical record:

Name of Physician/Organization	Telephone Number	Fax Number	
_____	_____	_____	_____
Mailing Address	City	State	Zip
_____	_____	_____	_____

INFORMATION TO BE RELEASED FROM: *(Please do not fax any records, mail them)*

Sunwest Gynecology Associates tele.915.541.1144 fax. 915.54.1170
7430 Remcon Circle, Building B, Suite 100 El Paso, Texas 79912 Texas

PURPOSE OR NEED FOR THIS INFORMATION: (Please check one box)

- Moving Specialist Appt. Dissatisfaction Change of Insurance Plan

TYPE OF INFORMATION TO BE RELEASED: (No information will be released unless a box is checked)

General Release

- All Medical Records**
 1 year of Medical Records Excluding Protected Records
(includes hospital records)
 Most recent labs **Operative Notes** **Other**

Information Protected by State/Federal Law

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----------|
| <input type="checkbox"/> Drug Abuse Diagnosis/Treatment | From: _____ | To: _____ |
| <input type="checkbox"/> Alcoholism diagnosis/Treatment | From: _____ | To: _____ |
| <input type="checkbox"/> Mental Health Diagnosis/Treatment
(May include treatment of pain management and women's health or psychiatry) | From: _____ | To: _____ |
| <input type="checkbox"/> Communicable Disease and Related Information | From: _____ | To: _____ |
| <input type="checkbox"/> Genetic Testing Information | From: _____ | To: _____ |

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information, understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Legal Representative

Please Print Name of Signing Party

Date Signed

Copy Fee May Be Charged for Medical Records in compliance with TMB and HIPAA regulations Total:

Note: If this request is made by mail, this office requires the request be notarized by a State Notary Public.