**Women’s Integrated Healthcare, P.A.**

3025 N. Tarrant Parkway, Suite 150, Fort Worth, TX 76177 | 245 W. State Highway 114, Suite 330, Southlake, TX 76092

(817) 416-2229 · (817) 416-3667 Fax

**Medical Records Release Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  I authorize Women’s Integrated Healthcare, P.A. to  **RELEASE** my information to: |  I authorize Women’s Integrated Healthcare, P.A. to  **OBTAIN** my information from: |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Provider or Facility**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Fax**

**PURPOSE FOR THIS REQUEST (REQUIRED):** -Transfer of Care -Continuation of Care -2nd Opinion

-Attorney/Lawsuit -Personal File (Fees apply for personal requests) -Other (specify)

- Personal Request (Fees apply for personal requests.) Please let us know how you would like to receive your personal records request. Send via -Mailing Address -Pick up in office (Southlake or Alliance) -Patient Portal

**DATES OF RECORDS REQUESTED (REQUIRED): \_\_\_\_\_\_\_\_\_**TO \_\_\_\_\_\_\_\_

**RELEASE THE FOLLOWING RECORDS (REQUIRED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Office Notes  Diagnostic Studies  Imaging Reports  Labs/Pap Results  Entire Chart

 Other (specify):

 Yes  No HIV/AIDS: I consent to the release of any positive or negative test results of AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial:

 Yes  No Alcohol/Drug Abuse/Mental Health: I consent to the release of any records containing alcohol/drug abuse and/or mental health records with the rest of my medical records. Initial: \_\_\_\_\_

**This authorization will expire in ninety (90) days from the date of my signature unless I revoke the authorization prior to that time in written form, or unless otherwise specified by date, event, or condition as follows.**

**I understand that:**

* *Authorizing the disclosure of this health information is voluntary.*
* *I acknowledge that information used or disclosed to any entity other than a health plan or health care provider may no longer be protected by the Federal Privacy Law. Except in cases of clinical trials, the entity will not release condition treatment or payment on the individual’s providing authorization for requested use or disclosure.*
* *Women’s Integrated Healthcare, P.A. providers, employees, and contractors shall not be held liable either individually or collectively while acting in good faith under the provisions of this authorization.*
* *Personal Records Requests: There will be a charge for the requested records, $25.00 for the first 20 pages of medical records copied and $0.50 for each additional page(s), plus the mailing costs. Records may be sent via USPS mail or by fax.*

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_