General Medical Records Request and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: ____
Address: ____
____
Phone: ____
SSN: ______________________________________Date of Birth:_____/_____/_____

I authorize the custodian of records of: ____ to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ Billing records
- ☐ Laboratory/pathology records
- ☐ Ultrasound records
- ☐ Other (describe specifically) ______________________________

These records are for services provided on the following date(s): ___________________________________

Please send the records listed above to:

Austin Perinatal Associates
6500 N MoPac Epwy
Building 1, Ste 1205
Austin, TX 78731
p: (512)206-0101 f: (512)206-0212

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____ Signature of patient (or patient's legal guardian)

__________________ Date

______________________________________ Printed name patient (or patient's legal guardian)

____________________________ Austin Perinatal Representative