Complete Women's Wellness
GYNECOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name:_____ Date of birth:_____

Social Security Number:_____ Daytime Phone:_____

Information Release To: From:_____

_____ _____

_____ _____

_____ _____

Please Release The Following: (Check all that apply)

__Problem List __Mammograms __Progress Notes __History/Physical Exams

__Lab Reports __Sonogram Reports __Prenatal Records __Other(Specify)

- UNLESS OTHERWISE REQUESTED, REFERENCES TO HIV/AIDS TEST, COMMUNICABLE DISEASES, DRUG, ALCOHOL, AND/OF MENTAL HEALTH DIAGNOSIS/ TREATMENT WILL NOT BE DE-IDENTIFIED/DELETED FROM THE PHI BEING RELEASED.
- BY TEXAS LAW, THIS OFFICE HAS 15 DAYS TO PROVIDE THIS INFORMATION.
- THE TEXAS STATE BOARD OF MEDICAL EXAMINERS APPROVES AN INITIAL FEE OF $25.00 FOR THE FIRST 20 PAGES OF A RECORD AND A $.50 PER PAGE THEREAFTER.

PURPOSE OF NEED FOR DISCLOSURE:

__Continued Patient Care __Personal Use __Attorney/Legal

__Insurance Claim/Application __Disability Determination __Other (Specify)

I understand the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ Date:_____

Signature of patient or legal representative

_____ Date:_____

Relationship to patient

708 Hill Country Drive, Suite 300A, Kerrville, Texas 78028
Ph: (830) 895-7755 Fax: (830) 896-4309

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold Dr. Melissa Wampler, or any representative of W Complete Women's Wellness liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.

_____ _____ Date:_____

Signature of patient of legal representative Relationship to patient

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