Advanced OB-GYN ASSOCIATES

3201 E President George Bush Hwy
Suite 107, Richardson, TX 75082
Phone: 972- 276-9902
Fax: 972- 276-9819

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read this form carefully. The federal Health Insurance Portability and Accountability act of 1996 (HIPAA), requires that all of the following elements must be completed for an authorization to be valid.

Patient Name: _____ Date of Birth: _____
Previous Name: _____ S. S. Number: _____

I hereby request and authorize: (Circle Your Physician)

Wm. Richard Salter, M.D. Elizabeth Mosier, M.D Anu Gupta, M.D. Arden Moulin, WHCNP

To release the protected healthcare information on the patient named above to:

Person/Organization: _____
Address: _____
City, State, Zip Code: _____
Telephone Number: _____ Fax Number: _____

This request and authorization applies to: (check all that apply)

___ All Healthcare Information
___ Most Recent Progress Notes
___ Specific Dates: from (date) _____ to (date) _____
____ Pathology and/or Lab Reports
____ Other _____

Purpose of Request: ☐ Referral ☐ Transferring Care due to _____ ☐ Other _____

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration of this Authorization will be ninety (90) days from the date of signature.
- I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (Aids Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (Aids Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment.
- I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, the organization named above will not release my health information.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Re-disclosure:

Notice is hereby given to the patient or legal representative signing this Authorization that Advanced OB-GYN Associates cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies. The fee is as follows: $25 for the first 20 sheets copied, then 15 cents per sheet over 20.

_____ _____ _____
Signature of Patient/Guardian/Representative | Relationship to Patient | Date