ADVANCED OB-GYN ASSOCIATES
3201 E President George Bush Hwy
Suite 107, Richardson, TX 75082
Phone: 972- 276-9902
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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. Anu Gupta, M.D. Shefali Pappu, 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