



# Medical Records Authorization

**REQUEST RECORDS FROM:**

*Banks, Halderman, Allen, Kidd*  
*Carter, Brogan, Hall, Santamaria*  
*4541 Medical Center Drive*  
*McKinney, TX 75069*  
*Phone (972)542-8884 Fax (214)544-9449*

**RELEASE RECORDS TO:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

I authorize the above listed person(s), physician(s), firm or entity (or its agents, representatives, or employees) to release for inspection and copying, any and all of the Protected Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from the date/s of: \_\_\_\_\_ to \_\_\_\_\_.

- Entire Record – Inpatient       Radiology/X-Ray Reports       Operative Reports       Pathology Reports
- Entire Record – Outpatient       Newborn/Neonatal Records       Laboratory Reports       ER Records
- Labor & Delivery Records       Discharge Summary       Anesthesia Records

Other: \_\_\_\_\_

If requested by patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire in 30 days. Payments made to NCWHP for PHI is not for financial gain but for compensation only. I do not have to sign this authorization in order to receive treatment from North Central Women’s Health Partners. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to inspect or copy the PHI to be used or disclosed. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the contact information listed above.

REASON FOR REQUESTING RECORDS: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Special Authorization to Release HIV/AIDS, Mental Health and/or Drug Treatment Information**

I hereby authorize my HIV/AIDS, Mental Health and/or Drug Treatment information to be released to the party listed above.

Signature \_\_\_\_\_ DOB \_\_\_\_\_ Date of Authorization \_\_\_\_\_