

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize _____
(Patient Name) (Facility/Doctor)

(Address) (Phone) (Fax)

to release any and all medical records and information pertaining to any medical history to:

Flower Mound Women's Health, P.A.
Obstetrics, Gynecology, & Infertility
Sylvie H. Paroski, M.D., F.A.C.O.G., Amy S. Lungren, M.D., Margarita Edge, MSN, RN-C, WHCNP
3101 Churchill Drive, Suite 212
Flower Mound, Texas 75022
972-874-5588
972-874-3638 (Fax)

Patient's Name: _____ Date of Birth: _____

Reason for transferring records: _____

Please check which records are needed:

Discharge Summary	Laboratory Test(s)
History & Physical	Radiology Report(s)
Progress Notes	Pathology Report(s)
OP Report	Others (slides, films)
Emergency Record	<i>All Records</i>
Other _____	

Please include information related to (Initial):

AIDS or HIV infection Psychiatric care Treatment for alcohol and/or drug abuse

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected. I understand that treatment or payment cannot be conditioned on my signing this authorization except in certain circumstances such as for participation in research programs or authorization of the release of testing results for pre-employment purposes.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____