

MEDICAL RECORDS RELEASE
Fax to 281-392-7911

There is a \$25.00 charge for the first 20 pages or less, and \$0.15 for each additional page after 20.
 This fee must be paid BEFORE documents are produced.

Please fill in all blanks. Incomplete or altered forms will be returned by mail for completion before processing.

Allow 2 weeks to process completed requests.

I HEREBY AUTHORIZE:

Premier OB/GYN of West Houston, L.L.P.
23920 Katy Freeway, Suite 330
Katy, TX 77494

To furnish a copy of medical records, which may include information concerning the results and/or treatment of HIV, AIDS, Mental Health, Alcohol and/or Drug Abuse, of the patient listed below. Upon making this request I hereby release you, your physicians and employees from liability for following this authorization request.

IT IS PREMIER'S POLICY TO ONLY RELEASE MEDICAL RECORDS TO THE PATIENT.

For the purpose of:

- | | |
|--|--|
| <input type="checkbox"/> Insurance Claim Pending | <input type="checkbox"/> Personal Copy |
| <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> Application for Life/Health Insurance | <input type="checkbox"/> Legal Representation |
| <input type="checkbox"/> Moving out of town | <input type="checkbox"/> Change in Insurance Plan (Ins. : _____) |
| <input type="checkbox"/> Transferring care due to: _____ | |
| <input type="checkbox"/> Other: _____ | |

INFORMATION TO BE RELEASED: Please specify which time period is requested.

Date of Service: FROM _____ TO _____

- | | | | | |
|--|---------------------------------------|---------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Labs | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Prenatal Record | <input type="checkbox"/> All Records | <input type="checkbox"/> Other: _____ | | |

This authorization is valid for 120 days from the date of signature. Any changes in authorization must be in writing.

Regarding (Patient Name) _____

SS # _____ Date of Birth _____

Address _____

City _____ State _____ Zip code _____

Home Phone _____ Work Phone _____

Patient Signature _____ Date _____

This document or documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of the information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.