

Vernon & Waldrep OB-Gyn Associates

Kim D. Vernon, M.D., F.A.C.O.G.
Kathryn K. Waldrep, M.D., F.A.C.O.G.
Alison M. Elmquist, M.D., F.A.C.O.G.
Angela F. Walker, M.D., F.A.C.O.G.

7777 Forest Lane
Medical City Dallas
Building D, Suite 570
Dallas, TX 75230
(972) 566-4660 Fax (972) 566-6413

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Dr. _____ Fax: _____

Address: _____ Phone: _____

To disclose my medical records to Dr. _____

Address: _____ Phone: _____ Fax: _____

These records will include the following information as indicated

<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> MD Progress Notes
<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Non Stress Test Reports	<input type="checkbox"/> Bone Density Reports
<input type="checkbox"/> Mammogram Reports	<input type="checkbox"/> X-Ray/Sonogram Reports	<input type="checkbox"/> Other _____

Specify

(Copies only of the above information will be sent - original reports and photos are not released)

for the purpose of:

_____ Changing doctors due to: Insurance Change/Network provider Second Opinion Moving
 Personal Other _____

I am aware that these records may contain information relating to psychological testing or treatment, biofeedback training, alcohol/drug abuse and/or HIV (AIDS) testing results. Such disclosure shall be limited to the following specific types of information: _____

The patient has the right to revoke this consent in writing up to the time that records have been sent. This consent is valid for (60) days from the date of signature. I understand that there may be a fee for preparing this information.

I hereby release Vernon & Waldrep OB-Gyn Associates from any/all legal liability that may arise from the release of this information to the party named above.

Patient's Printed Name: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Patient's Birthdate: _____ Patient's Social Security Number: _____

Home Phone Number: _____ Work Number: _____ Cell Number: _____

To the Party Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

SIGNED: _____ DATE: _____

*(Signature of patient/spouse/parent/guardian/conservator/patient representative)

SIGNED: _____ WITNESS: _____

(If signed by other than patient, indicate relationship)

*Authorized representative must submit copies of legal documentation supporting assignment of this authority.

PLEASE SIGN AND RETURN THIS FORM TO VERNON & WALDREP OB-GYN ASSOCIATES AT THE ABOVE ADDRESS