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
Tara E. O'Connor, M.D.

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

AUTHORIZATION TO TRANSFER MEDICAL CARE AND MEDICAL RECORDS

I hereby authorize Dr. ______________________________ **FAX**: ______________________

Address: ______________________________ Phone: ______________________

To disclose my medical records to Dr. ______________________________ **FAX**: ______________________

Address: ______________________________ Phone: ______________________

These records will include the complete medical history from all treatments performed by Dr. Kim Vernon.

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. **The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease.** 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 request the transfer of my medical care and related medical records to Dr. ______________________ with Vernon & Waldrep OB/GYN Associate.

I hereby release Vernon and Waldrep 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: ____________

Per your quest and imply authorization, Vernon and Waldrep OPBGYN Associates will continue to be the custodian of all medical records generated by the physicians of Vernon and Waldrep OB/GYN Associates

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.

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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

___ History and Physical Exam
___ EKG Reports
___ Mammogram Reports
___ Laboratory Reports
___ Non Stress Test Reports
___ X-Ray/Sonogram Reports
___ MD Progress Notes
___ Bone Density Reports
___ 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 __ Personal __ Other ______________ __ Second Opinion __ Moving

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