Complete Women's Care Center
7900 Fannin, Suite 3000 Houston, TX 77054
Phone-713-791-9100 Fax-713-791-1016

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name_____ Previous Name _____

Date of Birth_____ Phone Number _____

Address_____

City/State/Zip_____

Please Check One of the following options:

☐ I would like records from another physician's office to be sent to Complete Women's Care Center

☐ I would like my records to be sent from Complete Women's Care Center to a different physician's office

☐ OB Patient transferring care Reason for Transfer_____

☐ I would like a copy of my medical record for my records

Doctor's Name_____ Speciality_____

Address_____ City/State/Zip_____

Phone Number_____ Fax Number_____

This request authorization applies to:

_____Healthcare information relating to the following treatment only_____

_____All healthcare information

_____Other_____

Information is needed for

_____Continued care _____Personal Use _____Insurance _____Legal _____Other_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).I understand that treatment or payment cannot be conditioned on my signing this authorization. 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 the authorization.

This authorization will expire in One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows:

_____ _____

Signature of patient Date signed

_____ _____

Patient's authorized representative Relationship