FLOWER MOUND WOMEN'S CARE

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Date: _____

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Date of Birth: ____/____/____

Social Security #: ____-____-____

From the office of : _____

_____

_____

For the Purpose of:
- □ Medical care
- □ Consult
- □ Second opinion
- □ Change of insurance
- □ Change of residence/moving
- □ Other: _____

Please release the following:
- □ Full Medical Records
- □ Surgical/Hospital Records
- □ Lab Results: _____
- □ Other: _____

Please send my records to:

Flower Mound Women's Care
400 Parker Square #245
Flower Mound, TX 75010
Tel. 972-899-9787 Fax. 972-899-9786

- □ Dr. Guy Van Dell
- □ Dr. Odette Limosnero

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ **YES**, I consent to the release of this information. ____ **NO**, I do not consent to the release of this information

I understand that the information release is for the specific purposes stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information and the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Office Manager.

IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT: I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold Odette Limosnero, MD, PA and/or Guy Van Dell, MD, PA liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Relationship to Patient (if Legal Representative) **Witness**