

515 West Mayfield Road
Suite 200
Arlington, Texas 76014
Phone: (817) 468-4689
Fax: (817) 465-7872



1670 East Broad Street
Suite 107
Mansfield, Texas 76063
Phone: (817) 453-1758
Fax: (817) 453-1763

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical records of:

Patient Name: _____ Date of Birth: _____

Social Security #: _____

Information release TO:

FROM:

DR. _____

Matlock OB/GYN
515 West Mayfield Road, Suite 200
Arlington, Texas 76014

_____ Progress Notes

_____ History/Physical Exams

_____ Labs

_____ Diagnostic Reports

_____ Other (Specify) _____

Purpose of Need for Disclosure:

_____ Continued Patient Care

_____ Personal Use

_____ Attorney/Legal

_____ Insurance Claim/Application

_____ Disability Determination

_____ Other (Specify) _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the day of my signature unless otherwise specified.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record 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 made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness

Date request completed _____ # pages copied _____