Sherri S. Levin, M.D. & Associates

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OBSTETRICS • GYNECOLOGY • INFERTILITY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(PLEASE READ CAREFULLY, AND SIGN ON ALL APPROPRIATE SECTIONS)

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FROM THE MEDICAL RECORDS OF:
PATIENT NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY#:_____
DAYTIME PH# (OPTIONAL) _____

INFORMATION RELEASED TO: (who gets the records)
_____
_____
_____
_____

INFORMATION RELEASED FROM:
Sherri S. Levin M.D. & Associates
929 Gessner Rd. St 2100
Houston, TX 77024
PH# 713-464-4111 FAX# 713-464-3116

PLEASE RELEASE THE FOLLOWING:
_____PROGRESS NOTES _____HISTORY/PHYSICAL EXAM _____ALL MEDICAL
_____X-RAY REPORTS _____LAB REPORTS RECORDS
_____OTHER_____

PURPOSE OF DISCLOSURE:
_____CONTINUED PATIENT CARE _____ATTORNEY/LEGAL _____PERSONAL USE
_____DISABILITY DETERMINATION _____INSURANCE APPLICATION
_____OTHER_____

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 DATE OF MY SIGNATURE UNLESS OTHERWISE SPECIFIED.

PATIENT SIGNATURE OR LEGAL REP_____DATE_____
RELATIONSHIP TO PATIENT_____WITNESS_____
********** INCLUDING INFORMATION PERTAINING TO **********
_____DRUG/ALCOHOL _____HIV/AIDS _____MENTAL HEALTH _____COMMUNICABLE TREATMENT

SIGNATURE_____DATE_____

*****COMPLETE THE FOLLOWING ONLY IF THE INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT******

THERE IS A FEE FOR RELEASING MEDICAL RECORDS. 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 SHERRI S. LEVIN, MD & ASSOCIATES LIABLE FOR ANY MISINTERPRETATION OF THE INFORMATION IN MY MEDICAL RECORD AS A RESULT OF NOT CONSULTING HER FOR THE CORRECT INTERPRETATION.

PATIENT/LEGAL REPRESENTATIVE SIGNATURE _____ DATE_____
RELATIONSHIP TO PATIENT_____ WITNESS_____

There is a small fee assessed to cover the cost of copying records which include paper, postage and staffing time