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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:
Sherri S. Levin M.D. & Associates
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Houston, TX 77024
PH# 713-464-4111
FAX# 713-464-3116

INFORMATION RELEASED FROM:

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, M.D. 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 _____

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