Release of Medical Records to Atlas OB-GYN

Patient Name: Other Names:

Address: Date of Birth:

City: State:

Zip:

Phone: SSN: - -

I hereby authorize (Name of person/agency
from whom information is requested):

Please include address:

To release information to: Atlas OB-GYN
2821 E. President Bush Hwy, Ste 270,
Richardson, Texas 75082

Medical Information to be released to include:
Complete Medical Record _____Progress notes dated
Labs dated _____Other

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.

I specifically authorize the release of data and information related to:

Substance abuse (alcohol/drug abuse) Yes No Not Applicable

Mental Health Yes No Not Applicable

HIV-Related Information (AIDS related testing)

Yes No Not Applicable

Patient or Legal Guardian: Date:

This authorization for release of information shall remain in effect no longer than ninety (90) days.