

ObGyn North
12201 Renfert Way, Suite 220
Austin, TX 78758
512-425-3825 Phone **512-425-3829 Fax**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

We are unable to process incomplete forms. Please complete all areas.

Records Requested:

- Complete medical records. Please initial and date the area below if HIV/AIDS test results is to be included.
- Records of care from _____(date) to _____(date) only.
- Other (please specify) _____ \
- Billing Records
- Confer with another person orally about information in my record. Specify person under "To"

I understand 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. Please initial your choice below.

Yes, I consent to the release of this information No, I do not consent to the release of this information.

Reason for Release:

- | | |
|--|---|
| <input type="checkbox"/> Change of physician | <input type="checkbox"/> Disability Claim |
| <input type="checkbox"/> Patient moving | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Consultation with another physician | <input type="checkbox"/> Please tell us why you are transferring: _____ |

FROM: (Need complete Name, Address, Phone)

TO: (Need complete Name, Address, Phone)

Name

Name

Address

Address

City, State, Zip

City, State, Zip

Phone

Fax

Phone

Fax

I, the undersigned, do hereby authorize the release of information described above from my medical record. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Christina Sebestyen, M.D., P.A. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will expire in six (6) months.

I understand a reasonable amount of time, not to exceed 15 business days, may be required to retrieve my records. A fee may be charged according to TMB guidelines (Texas Code 159.006(a)). The maximum fee will be \$25.00 for the first 20 pages and \$ 0.50 thereafter. This request will be processed once the required fee is received.

Signature of patient or legal representative
(If not patient, state relationship to patient and reason patient unable to sign.)

Date Signed

Patient's full name (Please print)

Social Security Number

Date of Birth