Las Colinas Obstetrics-Gynecology-Infertility Association, P.A.
3501 N. MacArthur Blvd., Suite 350 • Irving, TX 75062
Phone 972-257-5300 • Fax 972-257-5322
John J. Zavaleta, R.Ph., M.D., F.A.C.O.G. — Elida Martinez, R.N., WHNP
John R. Hanson, M.D. — Annie Saldaña, PA-C

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____, who resides at _____
In the city of _____ in the State of _____ hereby authorize:

Las Colinas Obstetrics-Gynecology-Infertility Association, P.A.
3501 N. MacArthur Blvd., Suite 350 • Irving, TX 75062
Phone 972-257-5300 • Fax 972-257-5322

To disclose (release) the following specific medical information by mail or fax to:
Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
From the Health Records of:
Patient's Name: _____
Date of Birth: _____ Social Security #: _____ Phone: _____
For the purpose of: _____
Please release the following:

_____ Problem List
_____ Progress Notes
_____ History/Physical Exam
_____ Medication List
_____ Immunization Record
_____ List of Allergies
_____ Other (Specify) _____

_____ X-Ray/Imaging Report
_____ X-Ray/Imaging Films
_____ Lab Results from (date) _____ to (date) _____
_____ EKG Reports
_____ Genetic Testing Information
_____ Other Diagnostic Reports (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). I may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

____ **Yes**, I consent to the release of this information. ____ **No**, I do not consent to the release of this information.
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 understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization with expire in six (6) months (180 days).

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative — Date

_____ _____
Relationship to Patient (If Legal Representative) — Date

A small fee is charged by Amras Record Management and Archiving for processing your request. If you have any questions regarding your records fee please contact them at 972-272-4335.