Authorization for Release of Medical Record Information

Name: ______________________________ DOB: ____________________

Previous Name: ______________________________ Phone: ____________________

Address: ____________________ City: ____________________ State: _____ Zip: __________

I hereby authorize:

Physician Name: ______________________________ Phone: ____________________

Address: ____________________ City: ____________________ State: _____ Zip: __________

To disclose information from (my / minor child) medical records to:

Cedar Park Women's Center
1401 Medical Parkway B, Suite 410
Cedar Park, TX 78613
Fax: 512.260.3911

Dr. Jennifer Meadows
Ph: 512.260.3636

Dr. Mikaela Rush
Ph: 512.260.9191

This information is needed for the following reasons: ______________________________

The specific information I wish to have released is (include dates of treatment):

Entire Medical Record
Entire Prenatal Record
Labs/Pap Smears/Biopsies
Operative Reports

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released. Please check one:

- ☐ **I DO** consent to have information disclosed
- ☐ **I DO NOT** consent to have information disclosed

This medical record may contain information concerning HIV and/or AIDS diagnosis treatment. Separate consent must be given before information can be released.

Please check one:

- ☐ **I DO** consent to have information disclosed
- ☐ **I DO NOT** consent to have information disclosed

______________________________ ____________________

Signature *(Parent/Legal Guardian if Minor)* Date