Katy Women's Care

Katy Women's Care, P.A.
23920 Katy Freeway, Suite #330, Katy, TX 77494
Phone: 281-392-2266 Fax: 281-392-3147

Consent and Authorization for Release of Information

Patient Name: _____ DOB:_____

I hereby authorize the following individual or organization to disclose the above named individual's health information:

Name: Katy Women's Care, P.A.
Address: 23920 Katy Freeway, Suite #330, Katy, TX 77494
Phone: 281-392-2266 Fax: 281-392-3147

This information may be disclosed to and used by the following individual or organization:

Name: _____
Address: _____
Phone: _____ Fax: _____

FOR THE PURPOSE OF:_____

Please release the following:

_____ Entire Record

Or:
____ Problem List
____ Progress Notes
____ History/Physical Exam
____ Medication List
____ Immunization Records
____ Other (specify)_____

____ Mammogram reports (dates)_____
____ Ultrasound reports (dates)_____
____ Laboratory results (dates)_____
____ Genetic testing information
____ Other diagnostic reports (specify)_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until: _____.

I understand the information in my health records may include information relating to sexually transmitted disease, acquired immune deficiency 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.

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

Complete only if information is to be released directly to the patient:
I understand that my medical records 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 entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold the disclosing organization liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of patient or representative of patient Date

_____ _____
If Representative, relationship to patient Witness

****** There is a fee for the release of medical documents from this office. ******

_____ _____
Signature of patient or representative of patient Date

_____ _____
If representative, relationship to patient Witness