SUNWEST GYNECOLOGY ASSOCIATES
7430 REMCON CIRCLE BLDG. B STE. 100 EL PASO TX 79912
TEL. (915) 541-1144/FAX. (915)541-1170

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Account # _____

Telephone #: _____ D.O.B. _____

INFORMATION TO BE RELEASED FROM:

I heareby authorize the following to release the medical information requested, contained in the patient's medical record:

Name of Physician/Organization	Telephone Number	Fax Number

Mailing Address	City	State	Zip

INFORMATION TO BE RELEASED TO: ***(Please do not fax any records, mail them)***

Sunwest Gynecology Associates	tele.915-541-1144	fax. 915-541-1170	
7430 Remcon Circle Building B Suite 100	El Paso	Texas	79912

PURPOSE OR NEED FOR THIS INFORMATION: (Please check one box)

☐ Moving ☐ Specialist Appt. ☐ Dissatisfaction ☐ Change of Insurance Plan

TYPE OF INFORMATION TO BE RELEASED: (No information will be released unless a box is checked)

General Release

☐ All Medical Records

☐ 1 year of Medical Records Excluding Protected Records
(includes hospital records)

☐ **Most recent labs** ☐ **Operative Notes** ☐ **Other**

Information Protected by State/Federal Law

☐ Drug Abuse Diagnosis/Treatment	From: _____	To: _____
☐ Alcoholism diagnosis/Treatment	From: _____	To: _____
☐ Mental Health Diagnosis/Treatment (May include treatment of pain management and women's health or psychiatry)	From: _____	To: _____
☐ Communicable Disease and Related Information	From: _____	To: _____
☐ Genetic Testing Information	From: _____	To: _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information, understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

_____ _____

Signature of Patient or Legal Representative | Please Print Name of Signing Party

_____

Date Signed

Copy Fee May Be Charged for Medical Records
in compliance with TMB and HIPAA regulations
Total: _____

Note: If this request is made by mail, this office requires the request be notarized by a State Notary Public.