MacArthur MEDICAL CENTER

3501 N. MacArthur Blvd., Ste. 500, Irving, Texas 75062
(**Medical Records Dept.**)
OB/GYN • Pediatrics
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CONSENT TO RELEASE / OBTAIN MEDICAL RECORDS

Patient Name: FIRST_____ **LAST**_____**PREVIOUS LAST NAME**_____

Date of Birth: _____ **Social Security Number:** _____

I hereby authorize MacArthur Medical Center to: (REQUIRED TO CHECK ONE)

☐ **OBTAIN RECORDS FROM** ☐ **RELEASE MY RECORDS TO** ☐ **RELEASE RECORDS TO MYSELF**

Name _____

Address _____

Phone _____**Fax** _____☐ **(For self-request records check if preferred to be called for pick up)**

I understand that if the recipient authorized to receive the information is not a covered entity, e.g., insurance company or non-healthcare provider, the released information may no longer be protected by federal and state privacy regulations.

The following information is requested and may be released:

☐ **ALL RECORDS**

☐ **Most recent office notes**
☐ **Prenatal Records (includes office visits, labs, and sonogram reports)**
☐ **Specific dates from**_____**to**_____
☐ **Other/Only**_____

☐ **Lab Tests**
☐ **Immunizations**
☐ **Sonogram Reports**
☐ **Operative Reports**

Purpose of disclosure: (PLEASE CHECK ONE)

☐ **Relocated** ☐ **Continuity of Care** ☐ **Attorney** ☐ **Sharing with PCP** ☐ **Personal Use** ☐ **Transfer of care (please state reason below)**
☐ **Other (please state reason)**

By checking ALL RECORDS, I hereby give my express consent to release all medical records regarding my treatment, including genetic information and testing, family history, psychological treatment, drug abuse, alcohol use, human immunodeficiency virus (HIV) infection including acquired immunodeficiency syndrome (AIDS) or test for HIV, or sexually transmitted diseases.

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying MacArthur OB/GYN in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this Authorization. The revocation will not affect any actions taken before receipt of the written revocation. I understand that copies of records are subject to a $25.00 minimum fee.

_____ _____/_____/_____

Print name of Patient or Representative **Date (MM/DD/YYYY)**

_____ _____

Signature of Patient or Representative **Daytime Phone Number**