WOODLANDS WOMEN'S CARE

1120 Medical Plaza Dr. Suite 255
The Woodlands, Texas 77380
Phone (832) 663-6367
Fax (832) 663-6371

STEVEN M. STRONG, MD **FRANCISCO LABANCA, MD**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

SSN _____ Phone Number _____ Maiden Name _____

Address _____

I hereby authorize _____

Phone Number _____ Fax Number _____

To release Information from the medical records of _____

To _____

Phone Number _____ Fax Number _____

For treatment dates _____

For the following purpose: ☐ Medical Care ☐ Insurance ☐ Other (detail below)

_____

_____

(select all portions that may apply)

☐ Abstract/Pertinent Information	☐ Lab	☐ MD Progress Notes
☐ Emergency Room	☐ Imaging/Radiology	☐ MD Orders
☐ H & P	☐ Cardiac Studies	☐ Entire Record
☐ Consultation	☐ Face Sheet	☐ Other _____
☐ Operative/Procedure Report	☐ Nursing Notes	_____

_____ **I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS Information.**
Initials

I, the undersigned, have read the above and authorize _____ to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization. It may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from release of this information and I, the undersigned, waive, on behalf of myself, my heirs, assigns and any person who may have an interest in the matter, all provisions of law relating to the disclosure of this Protected Health Information.

_____ _____ _____

Date *Signature of Patient/Parent/Conservator/Guardian* *Authority/Relationship to Patient*

**** Fees/charges will comply with all laws and regulations applicable to the release of Protected Health Information Payment is due at time of release.**