FETAL CARE CENTER
DALLAS

Kevin Magee, MD
Nicole Yost, MD
Zachary Rubeo, MD
Maggie Warren, DO
Timothy M. Crombleholme, MD
Reenu Eapen, MD
Maytham Al-Kubaisi, MD
Danielle Moye', MD

Authorization to Release Information

Name:_____ Birthdate:_____

Social Security Number:_____ Telephone Number:_____

I hereby authorize the party below to disclose my individual identifiable health information as described below, which may include information concerning communicable diseases such as HIV, AIDS, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that health care and the payment of my health care will not be affected if i do not sign this form.

Authorization is given by the undersigned to release the information specified below

From:_____
Name of Person or Organization to RELEASE Information

_____
Complete Address

_____
Phone Fax

To: **Fetal Care Consultants, LLC**
Name of Person or Organization to RELEASE Information

7777 Forest Lane, C-742 Dallas, Texas 75230
Complete Address

972-566-5600 **972-566-5680**
Phone Fax

Description of Information to be released:	**The Information is requested for the following Purpose:**
❑ Entire Record ❑ Ultrasound Reports ❑ Prenatal Record ❑ Operative Report ❑ Lab Reports ❑ Radiology Films/Reports	❑ Continuation of Medical Care ❑ Transfer of Care ❑ Patient's Request ❑ Other (Specify) _____ _____

The information should be released from_____ to _____

I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

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 that this authorization can be revoked by me at any time by submitting a written request. I understand that revocation will not apply if information has already been released.

_____ _____
Signature of Patient *Date*

_____ _____ _____
Signature of Authorized Person *Relationship to Patient* *Date*