FETAL CARE CENTER
DALLAS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, hereby authorize Fetal Care Consultants, LLC to disclose my medical records to a physician for continuity of medical care.

Physician Name: _____ Phone Number: _____

Address: _____ Fax: _____

The following records may be released: History and Physical Exam, Lab Reports, MD Progress Notes, Fetal Echocardiogram Reports, Non Stress Test Reports, Diabetic Education, Genetic Counseling Reports, Sonogram Reports and any other medical reports involved in my care at Fetal Care Consultants, LLC.

The patient has the right to revoke this consent in writing up to the time that records have been sent. This consent is valid for 60 days from date of signature. I understand there may be a fee for preparing this form.

I hereby release Fetal Care Consultants, LLC from any and all legal liability that may rise from the release of this information.

Patients Printed Name: _____Date: _____

Address: _____

_____ _____
Patient Signature Legal Guardian Signature

_____ _____
Witness Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation prohibits you from making any further disclosure of it without specific written consent from the patient. A general authorization for release of medical records or other information is not sufficient for this purpose.