FETAL CARE
CENTER

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:____
Organization to RELEASE Information

____
Address

____
Phone Fax

To: **Fetal Care Consultants, LLC**

7777 Forest Lane, D-1190, Dallas, Texas 75230
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*