AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ **Date of Birth:** ______________________________

Home Address: ____

Purpose of Request: ☐ Continuation of care ☐ Personal ☐ Legal ☐ Insurance ☐ Other ____________

I authorize Fetal Care Consultants, LLC to release to:

Name/Facility: ______________________________ Phone: ____________________

Address: ______________________________ Fax: ____________________

Date of service range (month/year): From: ________________ To: ____________________

If release to self, select method of release: ☐ In person ☐ Mail to home address ☐ Fax ____________

Please select records to be released:

☐ Sonogram report	☐ Laboratory result
☐ Fetal Echocardiogram	☐ Pediatric Echocardiogram
☐ Non-Stress Test results	☐ Diabetic Education report
☐ Genetic Counseling report	☐ Health & Physical
☐ Other:	

1. I understand that Texas allows fifteen (15) business days to process request.
2. I understand this authorization is voluntary, and the disclosure is made at my request.
3. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
4. I have a right to revoke this authorization at any time, and if I revoke this authorization, I must do so in writing. Any revocation will not apply to information that has already been released in response to this authorization.
5. I request this authorization to expire on ____________ or 60 days from the date signed below and covers only treatment for the date(s) specified above.
6. I hereby release Fetal Care Consultants, LLC from any and all legal liability that may rise from the release of this information.
7. If released to self, I understand there is a fee of $25 paid to Fetal Care Consultants, LLC.

______________________________ ____________________

Patient/Legal Guardian Signature Date

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Legal Guardian Name

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.

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