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Obstetrics and Gynecology
1252 Harwood Road
Bedford, Texas 76021
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MEDICAL RECORDS RELEASE FORM

☐ RELEASE **FROM**: Charles A. Safely, MD
1252 Harwood Road
Bedford, Texas 76021
FAX: 866-864-0401

☐ RELEASE **TO**: _____

_____

_____

I, the undersigned, authorize the release of medical information from the medical record of:

_____ Patient Name

_____ Patient Social Security Number

_____ Patient Date of Birth (MM/DD/YYYY)

FROM _____ TO _____(MM/DD/YYYY)

REASON FOR RELEASE:_____

Information to be released:

☐ History & Physicals ☐ Office Visits ☐ Operative Reports
☐ Mammograms/Sonos ☐ Discharge Summaries ☐ Pap Smears/Lab
☐ All ☐ Other-Specify:_____

» I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith. **This authorization expires ninety (90) days from the date of this signature.**

_____ Date:_____
Signature of patient or Legal Representative (Please specify relationship to patient).