

CHARLES A. SAFELY, M.D.
Obstetrics and Gynecology
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MEDICAL RECORDS RELEASE FORM

RELEASE TO: Charles A. Safely, M.D.
1252 Harwood Road
Bedford, Texas 76021
FAX: 866-864-0401

RELEASE FROM: _____

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

_____ Patient Name
_____ Patient Social Security Number
_____ Date of Birth (MM/DD/YYYY)

FROM _____ TO _____ (MM/DD/YYYY)

REASON FOR RELEASE: _____

Information to be release:

<input type="checkbox"/> History & Physical	<input type="checkbox"/> Office Notes	<input type="checkbox"/> Pap/ Lab Results
<input type="checkbox"/> Operative Notes	<input type="checkbox"/> Obstetrical Records	<input type="checkbox"/> Mammogram Report
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology Record	<input type="checkbox"/> Sono Report
Other _____		ALL RECORDS

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) prohibits 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).