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**AUTHORIZATION FOR THE USE OR RELEASE OF
PROTECTED HEALTH INFORMATION**

Name of Patient (Please Print)				Date of Birth	
Street Address	City	State	Zip	Phone Number	Cell Number
Maiden name or other name used for records				Practice Use:	Medical Record #
I hereby authorize: (Please print) Name:				To release to: (Please Print) Name:	
Address:				Address:	
Phone#:		Fax:		Phone#:	
				Fax:	

My last year's worth of records and:

- ? Operative Reports ? History & Physical ? Radiology Reports/Films
? Discharge Summary ? Other (*Specify*):

I ? **do** ? **do not** (check applicable box) authorize this information to be faxed. If YES, fax number:

Covering the period from _____ to _____.

_____**(Initial)** I understand that this authorization will include information relating to:
Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
Psychiatric care
Treatment for alcohol and/or drug abuse
Genetic Testing

If any, except as specifically stated here: _____.

This information is to be disclosed for the purpose of: _____.

The date, extent or condition upon which this authorization expires is ___/___/___ not to exceed 24 months (except for research purposes, state "NONE" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than **Seven Oaks Women's Center** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by **Seven Oaks Women's Center** concerning me, including incorporated records. I acknowledge that **Seven Oaks Women's Center** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **Seven Oaks Women's Center** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **Seven Oaks Women's Center** is not responsible for completeness, legibility, or omissions used by the copying of any medical records from another institution.

Signature of patient or patient's representative Date

Printed name of patient's representative: _____

Relationship to patient: _____

Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this shall be fined or imprisoned.



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Effective 10/1/2009

Medical Record's Release Update:

It is the policy of Seven Oaks Women's Center to send up to one year of the patient's Medical Record. This includes the patient history, radiology, and operative reports.

Upon your review of the patient medical documentation should there be a need for additional medical history please specify in your request the information required.

This will help our Medical Records department expedite the processing time to meet your needs.

210-692-9500
210-616-9300 (fax)