GUADALUPE VALLEY
WOMEN'S HEALTH CARE CENTER

Release of Medical Records

PATIENT INFORMATION

Name:
DOB:
Address:

I hereby authorize **Guadalupe Valley Women's Health Care Center**:
Phone: (830) 372-0600
Fax: (830) 372-0602

To release, disclose, and deliver the following medical information described below to:

Name:
Phone:
Fax:

All ☐ Progress Notes ☐ Pap Smears ☐

Pathology ☐ Lab Reports ☐ Operative Reports ☐

OB Progress, Flow Sheet, Sonos, Labs, Pap, Pertaining to Pregnancy ☐

I specifically authorize the release of all medical information relating to the above named patient including but not limited to the following categories protected by the state of federal law: (1) Substance abuse(drug or alcohol) treatment (2) Mental health and (HIV-AIDS) related information, if such information is contained in the records. This request includes any report, correspondence, test results, and if any other information contained in the records, whether generated by the authorized provider or any entity.

I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the the disclosure described above, I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality.

I authorize the release of the information as indicated above

Patient signature: Date:

Witness signature: