MELANIE HENDRICKS PAGETTE, MD
MOCKINGBIRD OB/GYN, PA
OBSTETRICS AND GYNECOLOGY
7700 Cat Hollow Drive, Suite 202
Round Rock, Texas
phone (512)238-6688 fax (512) 238-6638

Printed Name:____________________________

Date of Birth: ___________________________

Address: ____

____

Social Security #:_____________________________________Telephone: ___________________________

Information To Be Released – Covering the Periods of Health Care

From (date) ____________________________________to (date) ____________________________________

From (date) ____________________________________to (date) ____________________________________

Please check type of information to be released:

☐ Entire medical record	☐ Pathology report	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results/reports	☐ X-ray reports	☐ X-ray films/images
☐ Operative report	☐ Emergency room record	☐ Itemized bill

☐ Other (specify) ____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other (specify) ____

Person Authorized to Release Information

Name: ____

Address: ____

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Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and /or other sensitive information, I agree to its release. *Check one:* ☐ Yes ☐ No ________________Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. *Check one:* ☐ Yes ☐ No ________________Initials

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 7700 Cat Hollow Drive, Suite 202, Round Rock, TX 78681. Unless revoked, this authorization will expire on the following date or event____________________. If no expiration date is set forth, this authorization will expire 180 days from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Mockingbird Ob/Gyn, PA to use and disclose the protected health information specified above.

Signature: ____ Date:________________________

Authority to Sign if not patient: ____

Identity of Requestor Verified via ☐Photo ID ☐Matching Signature ☐Other, specify _________________________