CYPRESS WOMEN'S CENTER
21216 Northwest Freeway Suite 520 Cypress, TX 77429
Phone: (281)955-7900 ▪ Fax: (281)955-0700

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FROM THE MEDICAL RECORDS OF:

Patient Name: ______________________ Date of Birth: __________ Phone: __________

Street Address: ______________________ City, State, & Zip code: ______________________

To Be Released TO ☐ FROM ☐

FACILITY: ______________________

PHONE: ______________________

FAX: ______________________

To Be Released To ☐ FROM ☐

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INFORMATION TO BE DISCLOSED – COVERING THE PERIODS OF HEALTH CARE:

FROM (DATE): ______________________ TO (DATE): ______________________

_______ History/Physical
_______ Progress Notes
_______ Prenatal Care Records
_______ Mammograms/Bone Density Reports
_______ Laboratory Results
_______ Radiology/Ultrasounds
_______ Operative/Pathology Reports
Other (specify): ______________

Purpose For Disclosure:

_______ Continued medical care
_______ Attorney/Legal
_______ Disability Determination
_______ Personal use
_______ Insurance Claim/Application
Other (specify): ______________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature. ***I am aware that the first time I request my records there will be no charge, additional requests will require a fee of $25.*** Cypress Women's Center will not be held responsible for lost or misplaced records.

______________________ Signature of patient or legal representative

______________ Date

______________________ Relationship to Patient

______________ Witness