

**Patient Identification**



**MELANIE HENDRICKS PAGETTE, MD  
MOCKINGBIRD OB/GYN, PA  
OBSTETRICS AND GYNECOLOGY  
7200 Wyoming Springs Drive, Suite 1100  
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 c onsultation	At the request of the patient	Billing or claims payment
----------------------------	-------------------------------	---------------------------

Other (specify) \_\_\_\_\_

**Person Authorized to Release Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**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 7200 Wyoming Springs Drive, Suite 1100, 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 \_\_\_\_\_