

# PATIENCE MILLER OB-GYN, PLLC

7922 Ewing Halsell, Suite 420 San Antonio, Texas 78229 Office: 210-614-8900 Fax: 210-614-8901  
**AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION**

\_\_\_\_\_  
Name of Patient (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street City State Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Maiden name or other name used for records

\_\_\_\_\_  
Practice Use: MedRec#

**I hereby authorize** (Please Print)

**To release to:**

Dr. Patience Miller

7922 Ewing Halsell, Suite 420

San Antonio, Tx 78229

The following information from my records:

- Complete Health Record(s)  History & Physical  Radiology Reports/Films
- Operative Report  Laboratory Report  Sonograms/ Ultrasound Reports
- Progress Notes  Discharge Summary  Other (please specify) \_\_\_\_\_

I  do  do not (check applicable box) authorize this information to be faxed. If yes, fax number: \_\_\_\_\_

Covering period from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_(Initial) I understand that this authorization will include information relating to:

- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
- 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 12 months.** 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 of \$1.00 per page 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 or 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 **Dr. Patience Miller** and therefore are 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 **Dr.**

**Patience Miller** concerning me, including incorporated records. I acknowledge that **Dr. Patience Miller & Dr. Lillian Jones** have no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **Dr. Patience Miller** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **Dr. Patience Miller** is not responsible for completeness, legibility, or omissions caused 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 or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provisions of this law shall be fined or imprisoned.