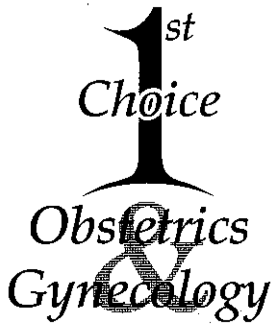

Shelby L. Hampton, MD • Tracy L. Turner, MD, FACOG

920 Medical Plaza Drive, Suite 400 • The Woodlands, TX 77380

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ Shelby L. Hampton, MD., F.A.C.O.G. _______ Tracy L. Turner, MD., F.A.C.O.G

I hereby authorize the release of information from the medical records of:

Patient Name: ________________________________ DOB ______________________

Address ________________________________ Phone # ______________________

Information Release To/From (circle one) : To/From (circle one): (Name, Address, Office # & Fax #)

1st Choice Obstetrics & Gynecology
920 Medical Plaza #400
The Woodlands, Tx 77380
281-882-8050 Office
281- 882-8057 Fax

____
____
____
____
____

Please Release the following:

___ Problem Visit
___ Progress Notes
___ Well Women Exam w/Pap
___ Lab Reports
Specific Dates: ______________________

___ X-Ray Reports
___ EKG Reports
___ Other Diagnostic Reports
___ Other (specify)

Please check information to transfer:

___ Continued Care
___ Attorney/Legal
___ Disability Determination

___ Personal Use
___ Transferring Care

Reason for transfer: ____

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 anytime except to the extent that action has been taken. This consent will expire in 90 days after that date of my signature unless otherwise specified.

______________________________ ______________________________
Signature of Patient or Legal Guardian Date

FEES/CHARGES WILL COMPLY WITH ALL LAWS AND REGULATION APPLICABLE TO RELEASE OF PROCTECTED HEALTH INFORMATION-PAYMENT IS DUE AT TIME OF RELASE.