

DEBORAH O'CONNELL, M.D.
WOMEN'S IMAGING CENTER



Authorization for Release of Patient Health Information (PHI)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize (name of provider releasing information) to disclose the above names individual's health information:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Description of Patient Information to be released

- | | |
|---|--|
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Laboratory report |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Radiology / imaging reports |
| <input type="checkbox"/> Most recent history & physical | <input type="checkbox"/> Radiology films |
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Mammogram |
| <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Breast ultrasound films |

I understand that the information in my health records may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug abuse or any such related information.

This information may be disclosed to and used by the following individuals or organization (receiving the information)

Deborah O'Connell Women's Imaging Center, 2200 Park Bend Blvd Suite 301 Austin, TX 78758
Office: 512-873-7237 Fax: 512-837-7237

The requested patient information will be used in the **continuing care** of the above named patient.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form. I may inspect or copy the redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. This authorization will expire One Hundred (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows:

_____ (date or event). I understand that if I revoke this authorization I must do so in writing.

Patient Signature (or Parent/Guardian)

Date of Signature

Employee/Witness