Victoria Women's Clinic

(361) 578-5233 FAX (361) 573-5803
1-800-747-0819

In accordance with legal and regulatory agency requirements, the health record is the property of Victoria Women's Clinic Associates. A fee of $25.00 is charged for the first 20 pages then $0.50 per page thereafter. A fee is only assessed when records are released directly to the patient.

Patient Information:

Patient Name: _____ DOB____/____/_____

Last four digits of your Social Security #:***-**-_____ Telephone #:_____

Information to be Released: □ **Mail** □ **Pickup**

From: _____ To: _____

_____ _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Please Release the Following:

____Entire Record ____All Records Last 2 Years
____Specific_____ ____Most recent office visit/test results
____Lab results ____ OB Records ___current pregnancy
____Pap smear results Year ____ ____ Previous pregnancy/delivered ___/___/____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

****A date range must be provided. If not indicated, only the last date of service will be sent.****

Purpose or Need for Disclosure:

____Transferring Care ____Attorney/legal ____Primary Care Physician
____Insurance ____Other_____

I understand that: The information released is for the specific purpose stated above. I **will not** hold Victoria Women's Clinic Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I also understand that my medical records may contain reports that only a physician can interpret. I may revoke this authorization at any time by notifying Victoria Women's Clinic. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient Signature: _____ **Date of Request:** _____