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:** ************MUST FILL OUT COMPLETELY********

Patient Name: _____ DOB _____/_____/_____

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

*****Information to be Released From:** ☐ **Mail** ☐ **Pickup** ☐ **Fax** ☐ **Email**

From: _____ **To**: _____

_____ _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Email: _____ Email: _____

*****Please Release the Following:**

_____ All Records Last 2 Years _____ Specific _____
_____ Most recent office visit/ test results _____ Lab results/Date_____
_____OB Records _____current pregnancy _____Previous pregnancy / delivered ___/___/___
_____Pap smear results Year _____ _____Ultrasound/Date_____

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 diseases, 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 _____ _____ Continuity of Care

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:** _____