Frisco GYN and Wellness
Kathryn J. Wood, M.D., P.A.
Beverly Johnson, PA-C
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Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____
(Please print)

Date of Birth: _____

I hereby request and authorize the release of my medical records **TO** or **FROM**:
(Circle)

Doctor's Name: _____

Telephone#_____ Fax#_____

Address: _____

This authorization applies to all reports from: _____including:
(Check all that apply) *(Approximate month and year)*

History_____ Physical Examination_____
Progress Notes_____ Physical Assessment_____
Blood tests/Urine Tests_____ Bone Density Measurements_____

Purpose of Disclosure: *(check all that apply)*
Continued Medical Care_____ Attorney_____Insurance_____Other_____

This authorization shall be effective until _____ or 120 days at which time this authorization shall expire.

I understand that information will be provided within 15 days from the receipt of request and a fee for preparing and furnishing this information is $25.00 for the first twenty pages and $.50 per a page thereafter according to the rulings set forth by the Texas State Board of Medical Examiners.

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I have the right to revoke this authorization in writing at any time by notifying Kathryn J. Wood, M.D. A revocation does not pertain to information use or disclosed by Kathryn J. Wood, M.D. prior to the time of the revocation. I understand that my Protected Health Information used or disclosed pursuant to this authorization maybe redisclosed by the entity receiving it and may therefore no longer be protected by law.

Patient Signature_____ Date_____

Witness_____ Date_____

** DO NOT FAX OVER 10 PAGES- PLEASE MAIL**