

CARTER • HAYS • POWERS & ASSOCIATES, LLP

OBSTETRICS GYNECOLOGY INFERTILITY

J.G.CARTER, M.D., P.A. TRACY D. HAYS, M.D., P.A. EDWARD J. POWERS, M.D., P.A.

Hello,

Attached is a copy of our medical records release form. Please fully complete, sign, date and return to the email below or fax to (214)824-3353. If the release is not fully complete or lacks a signature, your records will be delayed until the proper information is obtained. We do not accept electronic signatures due to patient confidentiality. If payment is required, we will contact you before sending your medical records. Our typical turnaround time is 1 to 2 weeks. Please email all requests to smoore@chmd-docs.com.

Please let me know if you have any questions.

Thank you!

Medical Records Clerk
1311 N. Washington
Dallas, TX 75204
P: (214)824-2563
F: (214) 824-3353

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I, authorize Dr. Carter Hays and Powers to release healthcare information of the patient named above to:

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

There is a fee which must be paid prior to the records being copied and mailed/sent. According to the Texas State Board of Medical Examiners, the allowable fee is \$25.00 for the first twenty pages and \$0.50 for each additional page.