North Cypress Women's Center
Medical Records Release

1. I Authorize:
Farhina Imtiaz, M.D.,P.A (NCWC)
9533 Huffmeister Road
Houston, TX 77095
281-463-9100 Fax: 281-463-6194

2. To Release To:
_____
_____
Phone:_____
Fax:_____

3. INFORMATION TO BE RELEASED: (Check all applicable)

☐ All Information ☐ All Progress ☐ Lab Reports
☐ Radiology ☐ Other:_____

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below:

By Signing below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ STD's ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature:_____ Date: _____

4. RECORDS FROM THE TIME PERIOD: __/__/__ through __/__/__

5. PURPOSE OF DISCLOSURE: (Check applicable purpose)

☐ Continue Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Workers Compensation Claim ☐ Other:

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the action has been taken. **Initial** _____

7. I understand that there is a fee for the duplication of these records that I am requesting. An estimate of these charges will be provided to me prior to the duplication of these records. **Initial** _____

8. I understand that it may take up to 7 business days to process the duplication of these records. **Initial** _____

Patient's Name Printed: _____

Patient's Signature: _____ Date: _____

Date of Birth: _____ Home #: _____ Work #: _____