Capital Surgeons Group, PLLC
Comprehensive, Compassionate General Surgery Care

Tim L. Faulkenberry, M.D., FACS
Mark R. Sherrod, M.D., FACS
Nancy G. Marquez, M.D., FACS
Steven M. Fass, M.D., FACS
Rob A. Fuller, M.D., FACS
Moya M. Griffin, M.D., FACS
Bridget M. Brady, M.D., FACS
Eric M. Acheson, M.D.
Teresa R. Kroeker, M.D.

MEDICAL RECORDS RELEASE

RECORDS TO BE RELEASED TO:

_____
Name

_____
Street Address

_____
City/State/Zip

_____
Phone Number Fax Number

PATIENT INFORMATION:

_____
Patient Name

_____
Date of Birth

_____
Social Security #

_____
Phone Number

By signing this form I authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____ Medical Record _____ Billing Record _____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s): _____

_____ Confer with other person orally about information in my medical record

_____ HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records. Initial _____ Date _____

The reason(s) or purpose(s) for this release of information are:

_____

I understand the information released is for the specific reason(s) or purpose(s) stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire ninety (90) days after the date of my signature unless otherwise specified in writing.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that you will provide this information within fifteen (15) business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

If applicable, I understand the fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

_____
Signed (Patient or person legally authorized to consent on patient's behalf)

_____
Date

3705 Medical Parkway, Ste. 250 ◆ Austin, TX 78705 ◆ Phone: 512.302.1210 ◆ Fax: 512.451.9752
12201 Renfert Way, Ste 240 ◆ Austin, TX 78758 ◆ Phone: 512.498.4850 ◆ Fax: 512.491.8387
301 Seton Parkway, Ste 102 ◆ Round Rock, TX 78665 ◆ Phone: 512.498.4860 ◆ Fax: 512.244.0443
www.CapitalSurgeons.com