P. Ronen, M.D., P.A., F.A.C.O.G.

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Houston, TX 77079
Phone 713-464-4444
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Release Records From:

_____

_____

_____

Release Records To:

_____

_____

_____

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

- ❑ **Complete record**
- ❑ **Records of care from the following dates: _____ to _____**
- ❑ **Records concerning the following conditions: _____**
- ❑ **Other, please specify: _____**
- ❑ **Confer with person(s) listed below about my medical information:**

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

The reason or purposes for this release of information are as follows:

_____

_____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above. Date this request terminates: _____

I, the undersigned, have read the above and authorize the staff of the indicated facility to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected. I herby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health information. I understand that you will provide this information within 15 business days from the receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Patient Name: _____ DOB: ____/____/____ SS#: _____-____-_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____