WELLSPRING
PLASTIC SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In accordance with legal and regulatory agency requirements, all medical records are the property of Wellspring Plastic Surgery (WPS)/Wellspring Craniofacial Group (WCG)/Pediatric Plastic Surgery (PPS).

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date: _____
Address: _____City, State, Zip Code _____

Release of Information From:
Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

Release of Information To:
WPS/WCG/PPS
911 W. 38th Street, Suite 101
Austin, TX 78705
Phone: 512-600-2888
Fax: 512-842-9228

How do you want the records sent? Please circle one: Mail Fax Email _____

Check which records you would like released:
__Complete Medical Records
__Alcohol/Drug Related
__Sexually Transmitted Diseases (includes HIV)
__Mental Health (psychology/psychiatry)
__Other: _____

*Article 4495b, section 5.08(j) Texas Revised Civil Statutes requires that an authorization for release of records include the reason for the release-Reason: _____
*Texas Medical Board Rule 165.2. Define a reasonable fee for providing paper copies of medical records as no more than $25 for the first twenty pages and $.50 per page for every copy thereafter. A reasonable fee for providing copies of medical records in electronic format is a charge of no more than: $25 for 500 pages or less and $50 for more than 500 pages. Also, a reasonable fee of up to $15 may be charged for executing an affidavit, if requested. A physician may charge separate fees for medical and billing records requested.

Informed Consent for Release of Confidential Information
___I understand that there is a fee for a copy of my medical record
___I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment and test results.
___I understand that the information released is for the specific purpose stated above.
___I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
___I will not hold WPS/WCG/PPS liable for any misinterpretation of the information, nor the mishandling of my medical records upon their release.

_____ _____ _____
Print Name Signature Date

Jeffrey Cone, Jr., MD Claude-Jean Langevin, M.D.

911 W. 38th St., Ste 101 Phone 512-600-2888
Austin, TX 78705 Fax: 512-842-9228

WELLSPRING
PLASTIC SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In accordance with legal and regulatory agency requirements, all medical records are the property of Wellspring Plastic Surgery (WPS)/Wellspring Craniofacial Group (WCG)/Pediatric Plastic Surgery (PPS).

I hereby authorize the release of information from the medical record of:

Patient Name: _____ DOB: _____
Address: _____City, State, Zip Code _____

Release of Information From:
WPS/WCG/PPS
911 W. 38th Street, Suite 101
Austin, TX 78705
Phone: 512-600-2888
Fax: 512-842-9228

Release of Information To:
Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

How do you want the records sent? Please circle one: Mail Fax _____ Email _____
Check which records you would like released:
_Complete Medical Records _Sexually Transmitted Diseases (includes HIV) _Photos
_Alcohol/Drug Related _Mental Health (psychology/psychiatry)
_Other: _____

*Article 4495b, section 5.08(j) Texas Revised Civil Statutes requires that an authorization for release of records include the reason for the release- Reason: _____ *Texas Medical Board Rule 165.2. Define a reasonable fee for providing paper copies of medical records as no more than $25 for the first twenty pages and $.50 per page for every copy thereafter. A reasonable fee for providing copies of medical records in electronic format is a charge of no more than: $25 for 500 pages or less and $50 for more than 500 pages. Also, a reasonable fee of up to $15 may be charged for executing an affidavit, if requested. A physician may charge separate fees for medical and billing records requested.

Informed Consent for Release of Confidential Information

___I understand that there is a fee for a copy of my medical record.
___I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment and test results.
___I understand that the information released is for the specific purpose stated above.
___I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
___I will not hold WPS/WCG/PPS liable for any misinterpretation of the information, nor the mishandling of my medical records upon their release.

_____ _____ _____
Print Name/Relationship if Minor Signature Date

Jeffrey Cone, Jr., MD Claude-Jean Langevin, M.D.

911 W. 38th St., Ste 101 Phone 512-600-2888
Austin, TX 78705 Fax: 512-842-9228