RELEASE OF INFORMATION
TO Sweetwater Ob/Gyn Associates Ltd., LLP

1. I, _____, hereby authorize:

   Physician/Practice Name: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Fax Number: _____ Phone Number: _____

   To release my protected health information
   TO: **Sweetwater Ob/Gyn Associates Ltd., LLP**, 16545 SW Fwy, Ste 150, Sugar Land, Texas 77479 Phone: 281.242.1400

   Fax: 281.207.2222, ATTN: _____

2. Release protected health information from the medical record of:

   Patient's Name: _____

   Birth Date: _____

   Social Security No: _____

3. Copies of the following records shall be used and disclosed:

   - Complete Medical Records; or
   - Other: _____ (specifically identify)

4. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

5. I understand that copies of the records indicated above will be (check all that are applicable):

   - Used by **Sweetwater Ob/Gyn Associates Ltd., LLP** providers & staff.
   - Other _____

6. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law. The information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

7. I understand that the purpose(s) of the requested use and disclosure is (are):

   - At the request of the individual.
   - Other: _____

8. I understand that I may revoke this authorization in writing at any time except to the extent that **Sweetwater Ob/Gyn Associates Ltd., LLP** has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to *Privacy Officer, **Sweetwater Ob/Gyn Associates Ltd., LLP**, 16545 SW Frwy, Ste 150, Sugar Land, Texas 77479 or Fax to 281.207.2222* stating my intent to revoke this authorization.

9. I Understand that **Sweetwater Ob/Gyn Associates Ltd., LLP** may not condition treatment on my completion of this authorization form. [Or, if the covered entity is permitted to condition services on the individual's completion of the authorization form under 45 C.F.R. § 164.508 (b) (4), this statement should explain the consequences to the individual of a refusal to sign the authorization (e.g. **Sweetwater Ob/Gyn Associates Ltd., LLP** Health Plan may deny you enrollment or eligibilityfor benefits if you fail to complete this authorization form)].

Signature of Patient or Patient's Legal Representative: _____ Date: _____

Printed Name of Legal Representative (if any): _____

Representative's Authority to Act for Patient: _____