AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name_________________________________ Date of birth __________

Social Security #______________________________

I authorize the following individual or organization to disclose the above named individual's health information:

_________________________________ Address:__________________________

To: Dr. Celeste Sheppard
Hill Country Maternal Fetal Medicine
4100 Duval Road, Bldg. 2, Suite 201
Austin, TX 78759
FAX 512/339-1011.

___________ All available records

___________ All records within the past 12 months

___________ All laboratory records

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: ______________________________.

_________________________________ _________________
Patient Signature Date

____
Patient Printed Name