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RIVERWALK OB/GYN, P.L.L.C.
www.riverwalk-obgyn.com

# AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Please Print) ______________________ Date of Birth ______________

Street Address ______ City ______ State ______ Zip ______ Phone ______________

Maiden name or other name used for records ______________________ Social Security # ______________

I authorize the following individual or organization to disclose the above named individual's health information:
Dr./Hospital Name: ______________________ Address: ______________________

This information may be disclosed **TO** and used by the following individual or organization:
Dr./Hospital Name: ______________________ Address: ______________________
Phone & Fax #: ______________________

For the purpose of: ______________________

Please release the following information from my records:

- ☐ Complete Health Record(s)
- ☐ Operative Report
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Discharge Summary
- ☐ Ultrasound Reports
- ☐ Other (please specify) ______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ **YES**, I consent to the release of this information. ____ **No**, I do not consent to the release of the information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

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 will expire on the following date, event, or condition: ______________________
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Collin Louison at (210)226-5420.

Signature of Patient or Legal Representative ______________________ Date ______________

Relationship to Patient (If Legal Representative) ______________________ Witness ______________

**COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:**

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold Riverwalk OB-GYN, P.L.L.C. liable for any misinterpretation in my medical records as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative ______________________ Date ______________

Relationship to Patient (If Legal Representative) ______________________ Witness ______________

**Prohibition on redisclosure:** This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined or imprisoned.

414 NAVARRO
SUITE 1200
SAN ANTONIO, TX 78205
TEL: 210.226.5420
FAX: 210.222.9443

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## GENERAL HISTORY FOR RIVERWALK OB/GYN PATIENTS

NAME:______________________________ DOB: ____________________

FIRST DAY OF LAST MENSTRUAL CYCLE:______________________________

LIST ANY MAJOR MEDICAL PROBLEMS: ______________________________

______________________________________________________________

Please indicate if any of your relatives or yourself has had any of the conditions listed.

1. Cancer/TYPE: ______________________________
   SELF MOTHER FATHER SISTER BROTHER MGM MGF
   PGM PGF AUNT UNCLE OTHER

2. Diabetes: ______________________________
   SELF MOTHER FATHER SISTER BROTHER MGM MGF
   PGM PGF AUNT UNCLE OTHER

3. Hypertension: ______________________________
   SELF MOTHER FATHER SISTER BROTHER MGM MGF
   PGM PGF AUNT UNCLE OTHER

4. Heart Disease: ______________________________
   SELF MOTHER FATHER SISTER BROTHER MGM MGF
   PGM PGF AUNT UNCLE OTHER

5. Other: ______________________________
   SELF MOTHER FATHER SISTER BROTHER MGM MGF
   PGM PGF AUNT UNCLE OTHER

6. HISTORY/YEAR OF STD: __________ NONE TRICHOMONIAS CHLAMYDIA GONORRHERA
   GENITAL HERPES GENITAL WARTS HPV HIV SYPHILLIS
   OTHER: ______________________________

**PAST SURGERIES**

| | OPERATIONS | TYPE | DATE |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

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## PAST PREGNANCIES

TOTAL PREGNANCIES: ______

HOW MANY LIVING: ______

HOW MANY PRE-TERM: ______

HOW MANY ABORTIONS: ______

HOW MANY MISCARRIAGES: ______

| | DATE OF DELIVERY | VAGINAL | CESAREAN | COMPLICATIONS |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

## BIRTH CONTROL METHOD

START DATE: ______ PILLS: ______

IUD TUBAL VASECTOMY OTHER: ______

## SOCIAL HISTORY

1. DO YOU DRINK ALCOHOL: YES NO DRINKS/DAY: ______ DRINKS/WEEK: ______
   OCCASIONAL USE MODERATE USE HEAVY USE
2. DO YOU SMOKE CIGARETTES: YES NO NUMBER PER DAY: ______
   HOW MANY YEARS: ______ YEAR QUIT: ______
3. DO YOU CURRENTLY OR HAVE YOU EVER USED ILLEGAL DRUGS: YES NO
4. CAFFEINE USE: YES NO
5. DO YOU EXERCISE REGULARLY: YES NO
6. WHAT TYPE OF EXERCISE: Walk Run Jog Yoga Cycle Weight Training
   Team Sports Exercise Class Other: ______
7. MARITAL STATUS: S M D W SERPERATED
   HUSBAND/PARTNER NAME: ______

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## ALLERGIES TO MEDICATIONS

DRUGS REACTION

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

## PHARMACY

PHARMACY NAME ADDRESS PHONE ZIP

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

## CURRENT MEDICATIONS PRESCRIPTIONS AND NON-PRESCRIPTIONS

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

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