El Paso Perinatology
Dr. Harlass / Dr. Velazquez

Authorization for Release of Information

I authorize El Paso Perinatology to release all medical information including but not limited to, history and physical reports, laboratory reports, physician progress notes and physician consultation dictations, I authorize the release of information on psychiatric conditions, sickle cell anemia, alcohol, drug abuse and r blood –borne diseases such as hepatitis, Human Immunodeficiency Virus (HIV) and Acuired Immune Deficiency Syndrome (AIDS) diseases requested by my health insurance carrier Medicare, Medicaid or any other third-party payers. I authorize El Paso Perinatology to release all medical information to my referring physician and my primary family physician. I authorize El Paso Perinatology to contact my insurance or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to El Paso Gerontology, I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law.

I agree that these provisions will remain in effect until I provide written revocation to El Paso Perinatology.

Signature of Patient / Legal Guardian: _____

Date: _____