Genoveva Nicoleta Prisacaru, MD, FACOG
Seven Hills Women's Center
Obstetrics & Gynecology
phone 512.442.2300
fax 512.442.2303

CONTINUATION OF CARE REQUEST

REQUESTED FROM: **Practice:** _____ **Fax:** _____
Phone: _____

RETURN RECORDS/INFORMATION TO:
Genoveva Nicoleta Prisacaru, MD, FACOG **Fax to: 512.442.2303**
Seven Hills Women's Center, 512.442.2300

PATIENT INFORMATION:

Name:_____ Date of Birth: _____

Address: _____ City:_____ ST: _____ Zip:_____

Hm phone: _____ Cell phone:_____ SSN: _____

Covering the Period of Health Care: Date of Service: _____
To (date): Ongoing / Present

Information to be released: (Reports may include information on drug/alcohol/psychological/HIV or communicable disease treatment.)

- ☒ History & Physical
- ☒ Progress Notes
- ☒ Radiology/MRI/CT
- ☒ Consultations
- ☒ EKG
- ☒ Other _____
- ☒ HIV/AIDS
- ☒ Laboratory

Purpose for release of information:

- ☐ Personal Use
- ☒ Continuing Medical Care
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Social Security/ Disability
- ☐ Other _____

Patient Authorization:

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/ state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

Printed Name:_____ **Phone:** _____

Signature: _____ **Date:** _____