VITAE CLINIC
OBSTETRICS & GYNECOLOGY

Jeremy Kalamarides, D.O. | Blake Weidaw, M.D.
Samantha Padilla MSN, APRN, FNP-C, | Heather Kalamarides, MAT, CFCP
Phone: (512) 458-6060 Fax: (512) 458-6070 Address: 1600 W 38th St. #115 Austin, TX 78731

To process the request, this form needs to be filled out completely

Patient Name: _____ Date of Birth: _____ Last 4 Digits of SSN: _____
Phone Number: _____ Address: _____

☐ **RELEASE** Medical Records
I authorize Vitae Clinic to release records to: _____
Name/Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

☐ **REQUEST** Medical Records
I authorize _____ to disclose medical information to: Vitae Clinic
Name/Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Please specify the medical records to be released. You may choose to release your complete medical record or particular information with date range. From _____ to _____

☐ **Complete Medical Record(s)**
☐ Discharge Summary
☐ Clinical and/or Progress Notes
☐ Ultrasounds
☐ Radiology Reports
☐ Laboratory Test
☐ Pathology
☐ Operative Reports
☐ Medication List
☐ Immunizations
☐ Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY THE STATE OR FEDERAL LAW.
I specifically authorize the release of data and information related to: (circle all that apply)

Substance abuse (alcohol/drug abuse):	Yes	No	Not Applicable
Mental Health:	Yes	No	Not Applicable
HIV- Related Information (AIDS related testing):	Yes	No	Not Applicable

Signature (or Legal Guardian) _____ Date: _____

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

This authorization for the release of information shall remain in effect for no longer than ninety (90) days.