**LakeView Women’s Healthcare Associates**

Michael W. Cowart, M.D., P.A.

6617 Heritage Parkway, Suite 100

Rockwall, Texas 75087

972-475-3030

Welcome to our practice! We look forward to meeting you!

Please complete the enclosed forms and bring them with you to your appointment. We ask that you arrive 15 minutes prior to your scheduled appointment.

If a minor child is being seen, a parent or legal guardian must sign a release form giving the physician and / or medical staff permission to give medical care to the minor. If a parent or legal guardian cannot accompany the minor to their appointment at our office, the release must be signed and notarized before our physician and / or staff will see the minor patient.

Our fees for an initial visit will range from $133.00 to $371.00, this does not include fees for labs, pathology, or other services rendered at the time of your visit. Payment is expected at the time of service. For our patients with HMO, PPO or EMO coverage, please be advised that:

* We must receive a valid authorization number (if referral is required) prior to the visit. It is your responsibility to obtain referral from your Primary Care Physician. The exam will be rescheduled if you do not provide the referral number.
* All co-payments will be collected at the time of service
* All non-covered services will be billed to you.

If you are unsure of your insurance carrier’s policies or requirements, please call them or your Primary Care Physician.

In the event you cannot keep your scheduled appointment, please call us 24 hours in advance. Our office charges a $25.00 fee for no show appointments.

Please call us if you have any questions. We look forward to seeing you.

Sincerely,

Lakeview Women’s Healthcare Associates

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**Patient Information:**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_

Referring Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_.\_\_\_\_\_

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to receive text YES NO

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (please circle): single married divorced widowed

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder Information:**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT**

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient’s physician.

\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**

In consideration of services rendered, I hereby transfer and assign to LakeView Women’s Healthcare Associates all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient’s record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic’s charge, including but not limited to medical service companies, insurance companies, workman’s compensation carriers, welfare funds or the patient’s employer.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

3. **FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney’s fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient’s general agent to execute the above and accepts its terms.

\_\_\_\_\_\_\_\_ (initials)

4. **MEDICARE / MEDICAID** Patient’s certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

5. **USE OF COPIES** I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

6. **PAYMENT RESPONSIBILITY** I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. The following are some guidelines that may result in denial of service(s):

Plan Maximum or not covered under plan provisions

Not eligble for coverage on the date(s) services rendered

Routine physical, other examination, or preventative service

Routine services not covered

Pre-existing conditions may not be covered

Payment’s reflects carrier’s determination of usual and customary charge for this service

Expenses are not payable due to other benefit limitations on the plan and are the responsibility of the insured

I understand it is my responsibility to pay for service(s) rendered, even if my insurance carrier determines that, according to it’s guidelines, the service(s) are not reasonable and necessary. I also agree to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

7. **RETURNED CHECK POLICY**  I understand that there is a fee of $50 for any returned checks and it will be my responsibility to pay that fee in addition to the original check amount in the event that there are insufficient funds available at the time the check was deposited.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

8. **NO SHOW / LATE CANCELLATION POLICY** I understand that LakeView Women’s Healthcare Associates has a 24 hour notice policy for cancellations. I agree to pay a $25 fee per occurrence for any no show appointments.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

PATIENT’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

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**HIPAA Notice of Privacy Practices**

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

**Lakeview Women’s Healthcare Associates** is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

**Your rights under the Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its website.

**You have the right to authorize other use and disclosure** - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information** - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request an disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

**How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare -** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person’s involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker’s compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

**Privacy Complaints**

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us.

We will not retaliate against you for filing a complaint.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised Date: 05-14-2014 Publication Date: 04-14-2003

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PATIENT HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Doctors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GYNECOLOGICAL HISTORY

Are you sexually active? YES NO

Contraception method: Condoms Pill IUD Vasectomy Withdrawal Implant Tubal Ligation

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any problems with contraception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you desire birth control at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you dissatisfied with your current birth control method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result of last pap smear NORMAL ABNORMAL

HPV Test POSITIVE NEGATIVE

HPV Vaccine Received Completed Not Completed N/A

Date if yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an abnormal pap smear? YES NO

If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Sexually transmitted infections YES NO

Have you ever had a mammogram? YES NO

Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results of last colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last bone density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results of last bone density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take steroid, thyroid, seizure or bone medication? YES NO

Do you have changes in breast size? YES NO

Do you have breast pain, tenderness, masses? YES NO

Do you have any abnormal nipple discharge? YES NO

History of Cervical Dysplasia YES NO

History of Endometriosis YES NO

History of Fibroids YES NO

History of Infertility YES NO

History of Ovarian problems YES NO

History of PCOS YES NO

MENSTRUAL HISTORY

Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HYSTERECTOMY PREGNANT MENOPAUSE

How old were you when you had your first menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have menses monthly? YES NO

Length of menses (number of days on your cycle): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of menstrual cycle (number of days between cycles): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any gushing or clots? YES NO

Do you have any pain or cramps? YES NO

Do you take any drugs for cramps? YES NO Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you done a home pregnancy test? YES NO

If so, what was the date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: POSITIVE NEGATIVE

Were you on birth control at conception? YES NO

OBSTETRICAL HISTORY

Gravida (total number of pregnancies including all miscarriages, abortions, and ectopics) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Para (how many times you have delivered a baby greater than 20 weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Live Births: \_\_\_\_\_ Full Term Pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Premature: \_\_\_\_\_ Ectopics: \_\_\_\_\_ Multiple Births: \_\_\_\_\_ Living Children: \_\_\_\_\_ Induced / elective abortions: \_\_\_\_\_

PREVIOUS PREGNANCY DETAILS

*1st Pregnancy*

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gestational Age in Weeks: \_\_\_\_\_\_\_\_ Length of labor: \_\_\_\_\_\_\_

Weight at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: MALE FEMALE Anesthesia: EPIDURAL NONE

Type of delivery: VAGINAL CESAREAN MISCARRAIGE

Complications: YES NO Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preterm Labor: YES NO

Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*2nd Pregnancy*

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gestational Age in Weeks: \_\_\_\_\_\_\_\_ Length of labor: \_\_\_\_\_\_\_

Weight at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: MALE FEMALE Anesthesia: EPIDURAL NONE

Type of delivery: VAGINAL CESAREAN MISCARRAIGE

Complications: YES NO Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preterm Labor: YES NO

Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*3rd Pregnancy*

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gestational Age in Weeks: \_\_\_\_\_\_\_\_ Length of labor: \_\_\_\_\_\_\_

Weight at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: MALE FEMALE Anesthesia: EPIDURAL NONE

Type of delivery: VAGINAL CESAREAN MISCARRAIGE

Complications: YES NO Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preterm Labor: YES NO

Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*4th Pregnancy*

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gestational Age in Weeks: \_\_\_\_\_\_\_\_ Length of labor: \_\_\_\_\_\_\_

Weight at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: MALE FEMALE Anesthesia: EPIDURAL NONE

Type of delivery: VAGINAL CESAREAN MISCARRAIGE

Complications: YES NO Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preterm Labor: YES NO

Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST MEDICAL HISTORY

\_\_\_ Abnormal pregnancy \_\_\_ Mumps \_\_\_ Sexual Dysfunction

\_\_\_ Lung Disease \_\_\_ Rubella \_\_\_ Fibroids \_\_\_ Thyroid Disease

\_\_\_ Breast Disease \_\_\_ Infertility Care \_\_\_ Hepatitis \_\_\_ Heart Disease

\_\_\_ Abnormal Periods \_\_\_ Eye Problems \_\_\_ Eczema \_\_\_ Chicken Pox

\_\_\_ Liver Disease \_\_\_ Urine Loss \_\_\_ Rashes \_\_\_ Depression

\_\_\_Cancer \_\_\_Eating Disorder \_\_\_Anxiety \_\_\_Anemia

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with any of the following:

\_\_\_ Yeast Infection \_\_\_ Gonorrhea \_\_\_ Human Papilloma Virus

\_\_\_ Genital Herpes \_\_\_ Chlamydia \_\_\_ Bacterial Vaginosis

\_\_\_ Trichomoniasis \_\_\_ HIV (AIDS) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST SURGICAL HISTORY

DATE SURGERY HOSPITAL DOCTOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

Have you or any of your immediate relatives (mother, father, siblings, or grandparents) experienced any of the following? **Please check all that apply and notate which family member was affected.**

\_\_\_Bleeding Disorder Family Member: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_Stroke Family Member\_\_\_\_\_\_\_\_

\_\_\_Clotting Disorder Family Member: \_\_\_\_\_\_\_\_\_\_\_ \_\_Dementia Family Member: \_\_\_\_\_\_\_

\_\_\_High Blood Pressure Family Member: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_Diabetes Family Member: \_\_\_\_\_\_\_

\_\_Uterine Cancer Family Member: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_Thyroid Family Member: \_\_\_\_\_\_\_

\_\_Breast Cancer Family Member: \_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Alcoholism \_\_\_ Heart Disease

\_\_\_ Diabetes \_\_\_ Drug Abuse \_\_\_ Cancer (not breast)

\_\_\_ Ulcers \_\_\_ Depression \_\_\_ High blood pressure

\_\_\_ Anemia \_\_\_ Multiple Miscarriage

\_\_\_ Epilepsy \_\_\_ Arthritis \_\_\_ Suicide Attempt

SOCIAL HISTORY

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Language: ENGLISH SPANISH Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Level NONE OCCASIONAL MODERATE HEAVY

Smoking Status NEVER FORMER CURRENT

If yes, years of use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much? NONE 1PPW 2PPW 1/4PPD 1/2PPD 1PPD 2PPD 3PPD

Alcohol Intake NONE OCCASIONAL MODERATE HEAVY

Recreational Drug Use NONE OCCASIONAL MODERATE HEAVY

If yes, which drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet Intake REGULAR VEGETARIAN VEGAN GLUTEN FREE

SPECIFIC CARBOHYDRATE CARDIAC DIABETIC

Caffeine Intake NONE OCCASIONAL MODERATE HEAVY

Have you experienced sexual abuse or domestic violence? YES NO

Country of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic background:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational Level Less than 8th grade 8th Grade 9th Grade 10th Grade

11th Grade 12th Grade 2 Year College 4 Year College Post Graduate

Occupation :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation HETEROSEXUAL HOMOSEXUAL BISEXUAL

Seat belts used routinely? YES NO

Blood Transfusion acceptable in case of Emergency YES NO

Have you recently, in the last 12 weeks or during this pregnancy traveled to a Zika infected area? YES NO

Do you have symptoms associated with Zika (fever, rash, conjunctivitis)? YES NO

Blind or serious difficulty hearing? YES NO

Deaf or serious difficulty seeing? YES NO

Difficulty concentrating, remembering or making decisions? YES NO

Difficulty doing errands alone? YES NO

Difficulty dressing or bathing? YES NO

Difficulty walking or climbing stairs? YES NO

Are you currently sexually active with anyone who has traveled (within the last 12 weeks) to a Zika-affected area?

YES NO

Have you had sexual relations with anyone who has been positively diagnosed with Zika virus within the last 6 months? YES NO

Have you or your sexual partner recently (within the last 12 weeks or during a current pregnancy) traveled to any country in South America and/or the Caribbean? YES NO

IMMUNIZATIONS

Flu Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gardasil Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis A Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis B Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MMR (measles, mumps, rubella) Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tdap (tetanus, diphtheria, pertussis) Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Meningococcal Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumococcal Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chickenpox Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles Vaccine Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENETIC SCREENING

Are you greater than 35 years old? YES NO

Thalassemia (Italian, Greek, Mediterranean, Asian) YES NO

Neural Tube Defect YES NO

Congenital heart defect YES NO

Down Syndrome YES NO

Tay-Sachs YES NO

Sickle Cell Disease / Trait YES NO

Hemophilia YES NO

Muscular Dystrophy YES NO

Cystic Fibrosis YES NO

Huntington Chorea YES NO

Mental Retardation / Autism YES NO

Other Inherited Genetic or Chromosomal Disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other child with birth defect not listed above? YES NO

Recurrent pregnancy loss or stillbirth YES NO

INFECTION HISTORY

Live with someone with TB or exposed to TB YES NO

Patient / Partner has history of Genital Herpes YES NO

Rash or Viral Illness since Last Menstrual Period YES NO

History of STD (Gonorrhea, Chlamydia, HPV, Syphilis) YES NO

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES

NONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS

NONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LakeView Women’s Healthcare Associates**

Michael W. Cowart, M.D., P.A.

6617 Heritage Parkway, Suite 100

Rockwall, Texas 75087

972-475-3030

**E-Mail Consent Form**

This form is used to obtain your consent to communicate with you by email regarding your protected health information (PHI).

**LakeView Women’s Healthcare Associates** offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before granting consent to use e-mail for these purposes.

**LakeView Women’s Healthcare Associates** will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, LakeView Women’s Healthcare Associates cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

**Patient’s Acknowledgment and Agreement**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail between LakeView Women’s Healthcare Associates and me and consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that LakeView Women’s Healthcare Associates may communicate with me regarding my protected health information by e-mail.

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient E-mail Address:** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.\_\_\_\_\_\_](mailto:_________________________@________________.______)

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LakeView Women’s Healthcare Associates**

Michael W. Cowart, M.D., P.A.

6617 Heritage Parkway, Suite 100

Rockwall, Texas 75087

972-475-3030

**Release for Medical Records**

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Reference to Patient:

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

\_\_\_\_\_\_\_\_\_\_ Complete record

\_\_\_\_\_\_\_\_\_\_ Records of care from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ only

\_\_\_\_\_\_\_\_\_\_ Records of care concerning the following condition(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to the following person(s):

LakeView Women’s Healthcare Associates

Michael Cowart, M.D., P.A. / Theresa M. Conyac, M.D.

6617 Heritage Parkway, Suite 100, Rockwall, Texas 75087

Phone: 972-475-3030 Fax: 972-475-0707

|  |
| --- |
| **HIV/AIDS** . I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.  Initial Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

The reasons or purposes for this release of information are for CONTINUING / TRANSFER of care.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_