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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

I hereby authorize the requested information below to be RELEASED FROM:

Name/Facility: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Fax: _____

I hereby authorize the requested information indicated below to be RELEASED TO:

Name/Facility: _____ Attention: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Fax: _____

Information to be released: Specific Date Range: _____ Lab Reports: _____
 Imaging Reports: _____ History & Physical Exam: _____
 Pregnancy Records: _____ Other: _____

Purpose of Disclosure: Personal Treatment Legal Disability Second Opinion Insurance
 Continuing Care Transfer of Care (reason): _____ Other: _____

There is a \$20.00 fee for disability forms. This fee is due prior to the forms being completed. If we have referred you to a Physician for continuation of care there will NOT be a fee. For all others we follow the 2015 Medical Records Access Act Fees.

Please read the below information carefully:

I understand that this health information may include HIV related information and/or information relating to diagnosis and treatment of mental health, and alcohol and/or substance abuse. If any of these apply to you, please indicate whether or not you would like the information released and initial at the end of each statement.

- I Do I Do not want information on **Mental Health** released. Initial: _____
- I Do I Do not want information on **HIV/Aids test and related information** released. Initial: _____
- I Do I Do not want information on **Alcohol and/or Substance Abuse** released. Initial: _____

- I understand that by signing below I am authorizing my health information that is indicated to be released to the recipient(s) listed.
- I understand that this authorization is valid for 90 days from the date signed and that I may revoke this authorization in writing to Associated Obstetrics & Gynecology during that time.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy standards.
- I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
- I understand that I will receive a copy of this form once I have signed it.

By signing below, I acknowledge that I have read and understand this authorization.

Patient/Representative's Signature: _____ Date: _____
Relationship to Patient: _____

For Office Use Only			
Date of Request: _____	Patient Account: _____	Total Fee: _____	
Fee Collected: _____	Date Records Sent: _____	Fax	Mail Pickup
Name of person completing request: _____			