CENTENNIAL OB/GYN, P.A.
5757 Warren Parkway, Suite 210
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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION BY RELEASE OF MEDICAL RECORDS

Disclosure of Personal Health Information (PHI), as required by applicable Federal and State Law, will be permitted only by following the HIPAA Privacy Practices that are set forth in the Centennial OB/GYN, P.A. Privacy Notice. A Patient's Privacy will be maintained in all instances where use of PHI is applicable. A copy of this Privacy Notice is available effective August 15, 2015.

REQUEST RECORDS FROM:	PLEASE SEND THE RECORDS TO:
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

PATIENT INFORMATION:

Patient Name: _____ Social Security number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Date of Birth: _____

I, _____, authorize the above listed person/s, physician/s, firm or entity (or its Agents, representatives, or employees) to release for inspection and copying, and all of the Personal Health Information (PHI) listed below that pertain to my treatment, hospitalization, or care from the date/s of : _____ to _____.

❍Entire Record – Inpatient	❍Radiology/X-Ray Reports	❍Operative Reports	❍Pathology Reports
❍Entire Record –Outpatient	❍Newborn/Neonatal Records	❍Laboratory Reports	❍ER Records
❍Labor & Delivery Records	❍Discharge Summary	❍Anesthesia Records	❍Other: _____

REASON FOR REQUESTING RELEASE: ❍**Transfer care to: _____** ❍**2nd Opinion**

❍**Continuity of care (PCP)** ❍**Relocating** ❍**Other: _____**

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ❍I DO NOT WANT HIV OR MENTAL HEALTH INFORMATION RELEASED.

I understand I have the right to refuse the release of records for self-pay services to health plans requesting medical information. ❍I DO NOT WANT INFORMATION FOR SELF-PAY SERVICES RELEASED.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____ _____
If I fail to specify an expiration date, event or condition, this authorization will expire 180 days from the date (below) it is initiated.

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

The Patient's Authorization below confirms his/her agreement for this Disclosure of his/her PHI. Once a completed, signed Authorization is received in our office, please allow up to 10 business days for processing this request. A photocopy of this Authorization will have the same effect and force of an original.

Authorization of Patient or Personal Representative: _____ Date: _____

Patient's Printed Name: _____ Witness: _____