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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: _____