

women living well

OBSTETRICS & GYNECOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____ Social Security Number: _____

Patient Address: _____

I hereby authorize (physician's name): _____

To disclose records obtained in the course of my evaluation and/or treatment to:

Disclosure will include: (check all that apply) ALL record information Dates: _____

History & Physical Lab Reports Operative Reports Radiology Reports

Progress/Physician Notes Pathology Reports Other: _____

Please initial on each line below to include these specific records in this release. I understand that failure to initial the three (3) items below, indicates that I do not want or authorize those specific records released.

_____ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse.

_____ Records related to HIV testing and results and/or AIDS diagnosis or treatment.

_____ Psychiatric and/or psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including any narrative summaries, tests, social work assessment, medications, psychiatric examination, progress notes, consultations, and/or treatment plans.

_____ Records related to Genetic testing and results

I also understand the following:

I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for my health care provider to inform the requester that portions of the record have been withheld.

- This authorization shall remain valid unless revoked and will expire 1 year after signing. This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee the recipient will not redisclose my health information to a third party not subject to applicable federal and state law governing the use and disclosure of my health information.
- I understand that signing this authorization is voluntary and will not condition my treatment, payment, enrollment or eligibility for benefits.

Signature of Patient or Substitute Decision Maker

Date

If Substitute Decision Maker, state relationship

If Substitute Decision Maker, state reason

REASON FOR REQUEST:

- _____ Moving out of State
- _____ No Insurance
- _____ New Patient
- _____ Personal Records
- _____ Transferring Care

REASON: _____

METHOD OF DISCLOSURE:

- _____ Mail to above patient address _____ Hand delivered to patient
- _____ Mail to above provider _____ Faxed to above provider
- _____ Electronic Transfer

Signature of Completer: _____

Date _____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF HAND DELIVERED RECORDS

SIGNATURE

DATE