



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Last Name		First Name		MI	Maiden/Previous Name
Patient's Address		Street	City	State	Zip Code
Social Security Number		Date of Birth	Home Phone Number		

I hereby authorize, the following Facility to release the protected health information indicated below on the above named individual.

RECORDS TO BE RECEIVED FROM:

RECORDS TO BE SENT TO:

Name of Facility/Provider

Address

City State Zip Code

() - () -
Phone Number Fax Number

Name of Facility/Provider

Address

City State Zip Code

() - () -
Phone Number Fax Number

For the Following Purpose:

Physician/Facility Request Legal Purpose Personal Use Patient Request Change of Insurance Consult/Second Opinion Relocation

Other: _____ Expiration Date: ___/___/___

(If no prior notice of revocation is received, or expiration date is indicated, this authorization will expire 90 days from the date signed below)

INFORMATION TO BE DISCLOSED:

All Records	Office Notes Only	Laboratory Results	Prenatal Records
Mammogram Reports	Ultrasound Reports	Operative Report	Other: _____

For treatment/service date(s): ___/___/___ - ___/___/___

I understand that:

- The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrom (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the above named facility.
- Revocation will not apply to information that has already been released in response to this authorization/
- Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law legislations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore my request may not be honored.
- Authorizing the use or disclosure of the information indentified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

Signature of Patient or Legal Representative _____ Date ___/___/___ Witness Signature _____ Date ___/___/___

If signed by a legal representative, indicate the relationship to the patient or authority to act for patient. _____
Fees/charges will comply with all laws and regulations applicable to release protected health information.

OB-Gyne Use: Date Received: ___/___/___ Date Completed: ___/___/___