645 N. Arlington Ave., Suite #400
Reno, Nevada 89503
Phone (775) 329-6241 Fax (775) 329-4921

WHEN SENDING RECORDS PLEASE ENSURE THAT THIS FORM IS ATTACHED!

Patient Name:______________________________________ SS Number:____________________ DOB: ____________

Choose One Option Below

1. Consent to **REQUEST** my Medical Information **FROM**:	2. Consent to **RELEASE** my Medical Information **TO**:
Provider Name:	Provider Name:
Phone:	Phone:
Fax:	Fax:
Address:	Address:
Please Release: ❑ All Records ❑ Other: ______________ ______________________________ ______________________________ *Please send records via Fax to OB/GYN Associates at (775) 329 4921 or by PDF disc only	Please Release: ❑ All Records ❑ Other: ______________ ______________________________ ______________________________ ______________________________

Please initial each item below to indicate your understanding:

_____ I understand 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 understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

_____ I authorize OB/GYN Associates to use or release/disclose my health information as directed above.

This authorization will expire on (insert date or event):_________________. If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

____ _____ /_____ /______

Patient Signature (or Signature of Person Completing form if Not Patient*) Date

*Relationship to patient: ❑ Parent ❑ Legal Guardian ❑ Other:___________________________________

OBG-146 (10/18)