OB/GYN associates

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WHEN SENDING RECORDS PLEASE ENSURE THAT THIS FORM IS ATTACHED

Patient Name:_____ SS Number:_____ DOB: _____

1. I Request and Authorize OB/GYN Associates to: ❑ Release ❑ Obtain From:

Name: _____

Address: _____

Fax Number or Email: _____

2. The Purpose of this Request is:

❑ Transfer of Medical Care ❑ Personal Use ❑ Other (reason required): _____

3. Medical Records to be Released or Obtained:

❑ All Medical Records (Visit Notes, Lab Work, Imaging, Pap Smear Reports, Hospital Records)

❑ Specific Dates / Record: _____

4. Method of Delivery of Requested Medical Records:

❑ Mail ❑ Pickup ❑ Encrypted Email ❑ Fax

Records can be put on a Flash Drive, Disc, or Printed (circle one)

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:_____