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OBGYN

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request AND/OR authorize the release of my healthcare information FROM/TO:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

( ) ALL MEDICAL RECORDS ( ) LAB REPORTS ( ) DR. NOTES ( ) INSURANCE

( ) PRENATAL RECORDS ( ) HOSPITAL ( ) DEMOGRAPHICS

( ) X-RAY/ULTRASOUND ( ) OTHER _____

_____

PURPOSE OF DISCLOSURE:

( ) CHANGING PHYSICIAN ( ) MOVING ( ) REFERRAL ( ) INSURANCE CLAIM

( ) LEGAL ( ) OTHER _____

I understand these records may include information on sexually transmitted diseases, AIDS, HIV, mental health, alcohol/drug abuse.

REVOCATION: I understand this authorization may be revoked in writing at any time. Unless otherwise indicated, this authorization will expire 90 days from the date of signature. The physician and the employees are released from the legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Medical records are released with five (5) to seven (7) business days from the date of receipt of this completed request form. Fee may apply to the request which may be the patient's responsibility.

Employee Signature: _____ Date Signed: _____

Patient Signature: _____ Date Signed: _____

DR. INTIALS: _____

DR. INTIALS: _____