

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

~ Records Released From Midtown OB/GYN ~

I authorize Midtown OB/GYN to **RELEASE** health information on the following individual:

Patient Name: _____ Date of Birth: ____/____/____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ SSN: _____

I authorize the information to be **DISCLOSED** to the following individual or organization:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

Information to be disclosed: (Specify dates where appropriate)

- | | | |
|--|--|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Medical Notes/Summary | <input type="checkbox"/> Operative/Procedure Reports |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> PAP/HPV Type | <input type="checkbox"/> Mammograms/Sonograms |
| <input type="checkbox"/> Bone Density | <input type="checkbox"/> Lab Results | <input type="checkbox"/> AIDS/HIV Information |
| <input type="checkbox"/> Other: _____ | | |

Purpose of disclosure:

- | | | |
|---|---|---|
| <input type="checkbox"/> Continuing Medical Treatment | <input type="checkbox"/> Residence Relocation | <input type="checkbox"/> Second Opinion |
| <input type="checkbox"/> Disability Insurance | <input type="checkbox"/> Patient Request | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> FMLA | <input type="checkbox"/> Other: _____ | |

Authorization & Signature:

- I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

- **I understand this authorization will expire one year from the date of signing.** I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

- I understand that this authorization is voluntary. I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Midtown OB/GYN from all liability arising from this disclosure of my health information.

- I understand and agree that I am responsible for the fees associated with my request: copying charges and postage related to the production of my information. I understand that the charge for this service is free for information sent to another health care provider, **\$15.00** for information sent or given directly to the patient, and **\$45.00** for information sent to all others.

**** Medical records may take up to 2 weeks to process ****

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: _____ Date of Birth: ____/____/____

Patient Signature: _____ Date: _____

(Guardian or legal representative)