My ObGyn

A division of OB/GYN Affiliates
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Authorization to Release Health Information

Physician or facility to provide records: _____
Address: _____ Phone: _____
_____ Fax: _____

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
_____ SS# last 4 digits _____

Person to receive records: _____
Address: _____ Phone: _____
_____ Fax: _____

Health Information to be Released:

☐ I am permanently transferring my care to another Physician? **Yes No**

☐ My entire medical record, or

☐ My health information related to the following treatment or health condition: _____
_____

☐ My health information related to drug/alcohol abuse

☐ My health information related to HIV/ AIDS

☐ My health information related to psychological / psychiatric conditions, including Psychotherapy notes

☐ My health information for the dates of: _____

This authorization is made for the following purpose:

☐ At my request;

☐ Other: _____

Conditions of Authorization

1. This authorization will expire on (date or event):_____
2. I may revoke this authorization at any time by notifying my health care provider in writing, and it will be effective on the date notified to the extent that my health care provider has already acted upon this authorization.
3. Once my health care provider discloses this health information, the person or organization that receives it may re-disclose it. Federal privacy laws may not longer protect it.

Signature: _____ Date: _____