Genesis Ob/Gyn

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HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT'S NAME: _________________________DOB: ____________SSN: _______________Ph:______________________

TO: ____ PH: ________________________ FAX: _______________________

ADDRESS: ____

FROM: ____

ADDRESS: ____

PURPOSE OF DISCLOSURE (Circle):

Transfer of Care   Continuity of Care   Insurance   Personal Use   Other (please specify)__________________

RECORDS TO INCLUDE:

This authorization pertains to the disclosure of records types indicated below between the following dates of service:

From: _________________________________ To: _________________________ or **ALL**

RECORDS TO INCLUDE (Circle all that apply):

Progess notes   Lab/Pathology Results   Immunization Records   Operative Reports

Imaging/radiology/mammogram Records   ALL records obtained by facility.   Other: ___________________________

I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, HIV testing results or AIDS information. _______________**Initials**

EXPIRATION: This authorization shall expire 180 days from the date of signature. I understand that this authorization may be revoked by me at anytime except to the extent that action has been taken. I have the right to revoke this Authorization at any time prior to 180 days by giving the healthcare provider written notice of revocation of this Authorization. ________________ **Initials**

RE-DISCLOSURE: I understand the information disclosed by this Authorization may be subject to re-disclosure by the receipient and no longer protected by the Health Insurance Portability and Accountablity Act of 1996.

I understand that:

- I have the right to refuse to sign this Authorization
- I have the right to receive a copy of this Authorization
- I have the right to inspect or copy the protected health information to be used or disclosured
- Fees/Charges will comply with all laws and regualtion applicable to release of information
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FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI & cost for supplies. If the charges will exceed $25, we will inform you approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

I have read the above and authorize the disclosure of the protected health information as stated.

____   ____________________   _________________________

Signature of Patient/Parent/Guardian   Date   Relationship to patient