Vandna Jerath MD

Authorization for Release of Medical Information

Patient's Name: ___________________________________ Date of Birth: ________________________________

Phone Number: ___________________________________ Social Security Number: _______________________

Release To: ______________________Optima Women's Healthcare, PLLC________________________________

Release From: ____

I authorize the above named health care provider to release the information specified below to the organization, agency, or individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication to appropriate practitioner or individual. I understand that with this authorization, all information contained in my chart/file shall be released, including lab results, alcohol/drug abuse information, STD, INFERTILITY, HIV, or Psychosocial/Psychiatric information.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by privacy regulations, the information described above may be disclosed and is no longer protected by those regulations.

I understand that this authorization will remain valid indefinitely unless otherwise specified. I also understand that I may revoke this authorization in writing at any time by notifying the Privacy Officer, except to the extent that action has been taken in reliance on this authorization.

I understand that Optima Women's Healthcare, PLLC may impose a reasonable fee for the copying and disclosure of my medical records. No fees shall be charged by a health care provider for requests for medical records received by another health care provider or to an individual regulated pursuant to Section 25-1-802(1) solely for the purpose of providing continuing medical care to a patient.

I understand that under CBME (Colorado Board of Medical Examiners) policy 40-7 states that 30 days is "reasonable notice" when records have been requested. When records are requested in response to a patient's exercise of the right to review their medical records under HIPAA, guidelines suggest a response within 30 days of a written request.

I understand that I, or my future health care provider will receive my medical records within the 30 days reasonable time allowed, in order of which the request (s) was received at Colorado OBGYN Associates.

I am requesting the following information be released to the above named organization/agency/individual:

- Complete Copy of Medical Records
- History and Physical Exam
- Discharge Summary
- Emergency Department Records
- Operative Reports, Consults
- Laboratory Reports
- Imaging Reports
- Prenatal Records

The purpose for which this information is to be used is:

- Further Evaluation/Treatment
- Personal Use
- Legal
- Insurance Reimbursement
- Verify Treatment Status
- Other __________________

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I understand that I may refuse to sign this authorization and that my refusal to sign will not reflect my ability to obtain treatment, payment, or my eligibility for benefits. I also understand that I may inspect or copy any information used/disclosed under this authorization.

____ Date _____________________

Signature of Patient or Representative

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Relationship to Patient