ASSOCIATES IN OBSTETRICS & GYNECOLOGY
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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE INFORMATION

1. Name:_____ DOB _____
2. I request/authorize you to furnish the indicated person/agency with copies of my (initial all that apply)

____ Outpatient Medical Records
____ Inpatient Medical Records
____ Mental Health Records
____ OB/GYN Records
____ Other_____

Requesting Records FROM	Send Records TO

3. **Information requested will be used for the following purpose** (initial all that apply):

____ Further Medical Care
____ Retirement
____ Personal Copy
____ Other (specify) _____

4. **Expiration** (This authorization will expire in ONE year from today unless otherwise specified)

Date _____ Initials _____

5. **Litigation** (initial in the line that applies)

____ I am not party to any pending or contemplated litigation
____ I am party to pending or contemplated litigation (state to what effect)

6. **Drug & Alcohol** (please initial)

____ I understand that my records may contain information regarding diagnosis or treatment for drug and/or alcohol abuse.

7. **STD/HIV/Aids** (please initial)

____ I understand that my records may contain information regarding diagnosis of HIV, AIDS Virus, or sexually transmitted diseases.

8. **Mental Health** (please initial)

____ I understand that my records may contain information regarding diagnosis or treatment of any mental health illness.

9. **Initial Each of the Following:**

____ I understand that if the person or entity that receives the information is not a health care professional or health plan covered by the federal privacy regulations, the information described may be re-disclosed and no longer protected by those regulations.
____ (If applicable) I understand that I will receive compensation for its use and disclosure of the information.
____ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information use/disclosed under this authorization.
____ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on the authorization.

Phone: _____ Date: _____
Signature (patient/authorized person): _____
Relationship: _____
Witness: _____ Date: _____