



# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME: (Last, First, MI): \_\_\_\_\_ D.O.B: \_\_\_\_\_

PHONE #: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**I, the above name patient, hereby authorize the release of my protected health information.**

**This form must be completed in it's entirety by the patient or patient representative in order to be processed.**

<b>I authorize the release of my records FROM:</b>
PHYSICIANS/ PRACTICE/ FACILITY NAME
ADDRESS OF FACILITY
PHYSICIAN PHONE/ FAX/ EMAIL

<b>I authorize the release of my records TO:</b>
PHYSICIAN/ PRACTICE/ FACILITY NAME
ADDRESS OF FACILITY
PHYSICIAN PHONE/ FAX/ EMAIL

**The information I wish to have released is:**

- All  Ultrasound Results  Mammogram  Labs  Pap Results  Prenatal Records  Substance Abuse  HIV/AIDS
- Genetic Testing  Mental Health Care  STD Results  Specific Dates of Service: \_\_\_\_\_  Other \_\_\_\_\_

**The purpose for the release of the health information:**  Transfer of Care  Legal  Other \_\_\_\_\_

**Duration of Authorization:** Unless otherwise specified, this authorization will expire one (1) year after the date of this request.

This Authorization will expire:  Date: \_\_\_\_\_

**Fees for copying medical records and processing time frame:**

• Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. [**\$2.00 per page for pages 1-10, \$1.00 per page for pages 11-20, \$0.90 per pages 21-60, \$0.50 for pages 61 and greater. There is an additional charge for postage.**] • **Please allow 2-3 weeks for processing.**

**Certification and Acknowledgement:** I certify that I am the patient or the patient's legal representative. I understand that I may revoke this authorization at any time by notifying Dedicated to Women OB-GYN in writing. Revocation will not apply to information that has already been disclosed in response to this authorization, and that the revocation will be effective except to the extent that Dedicated to Women OB-GYN has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If signing as the personal representative of the person, print your name and describe your authority to sign for the person and attach any legal documentation which authorizes signature on the member's behalf (Power of Attorney, Guardianship, etc.)*

Name: \_\_\_\_\_ Authority: \_\_\_\_\_

**FOR OFFICE USE:**  Records sent on \_\_\_\_\_  Transfer Group notified: \_\_\_\_\_