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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME: _____ DATE OF BIRTH: _____
Please print *MM/DD/YYYY*

FROM: Pursuant to the Health lnsurance Portability and Accountability Act (HIPAA), I hereby authorize the following provider:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: ( ) _____ FAX: ( ) _____

TO: To disclose to the party listed below:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: ( ) _____ FAX: ( ) _____

lf over 35 pages, please mail not FAX

WHAT: The following protected Health lnformation:

☐ ALL MEDICAL RECORDS GENERATED AT OFFICE, INCLUDING INFORMATION REGARDING THE FOLLOWING CONDITIONS (INITIAL THOSE CONDITIONS TO BE INCLUDED):

☐ SUBSTANCE ABUSE _____ ☐ PSYCHOLOGICAL CONDITIONS _____

☐ HIV/AIDS _____ ☐ BILLING INFORMATION _____

☐ ALL MEDICAL RECORDS GENERATED AT OFFICE DURING DATES FROM _____ TO _____
MM/DD/YYYY *MM/DD/YYYY*

☐ ONLY RECORDS AS SPECIFIED: _____

WHY: MOVING OUT OF AREA ☐ CHANGING PHYSICIANS ☐ 2ND OPINION ☐ SPECIALTY CARE

☐ OTHER _____

I understand this protected Health lnformation is being used by the facility for the purpose of providing healthcare or to pursue and receive reimbursement of claims from any and all responsible third parties, as allowed in the subscriber's health plan or insurance policy. This authorization shall be in force and remain in effect for 1 year from the date signed below unless I indicate otherwise.

I understand that, as set forth in the Privacy Notice, I have the right to revoke this authorization in writing at any time by sending written notification to Capital OB/Gyn. I understand that my revocation of this authorization will not affect any actions taken by Capital OB/Gyn in reliance on this authorization prior to the time it received my revocation. I understand that I have the right to receive a copy of this authorization upon request.

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❖ IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP AND AUTHORITY: _____

PRINTED NAME OF PERSONAL REPRESENTATIVE: _____