A WOMAN'S PLACE

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AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INORMATION

Please read and complete form thoroughly. Medical records cannot be released/obtained until this form is completed, signed by the patient or legal guardian and returned to our office. A possible fee may be charged.

Step 1:	**INFORMATION ABOUT YOU** **PLEASE PRINT!!** PATIENTS NAME: _____ DATE OF BIRTH: _____ Last First Initial MAIDEN NAME: _____ SOCIAL SECURITY NUMBER: _____ ADDRESS: _____ Street City State Zip PHONE NUMBER: (_____)_____ **WILL YOU BE RETURNING TO THIS OFFICE FOR FUTURE CARE? { } YES { } NO**
Step 2:	**I HEREBY AUTHORIZE OB-GYN GROUP { } OBTAIN FROM: { } RELEASE TO:** _____ Facility or Physician's name _____ Facility or Physician's address _____ Telephone # Fax # Attention to: **IF YOU ARE LEAVING THE PRACTICE AND TRANSFERRING TO ANOTHER PHYSICAN, PLEASE TAKE A MOMENT TO TELL US WHY YOU ARE LEAVING:** { } Moving from area { } Change of Insurance { } Unhappy with service { } Unhappy with quality of care
Step 3:	I WISH TO RELEASE/OBTAIN THE FOLLOWING INFORMATION PROVIDED ON: DATE RANGE: _____ Date Range { } All records (or specify below) { } Physical exams/history { } Pap results { } X-Ray/mammogram/ultrasound reports { } Blood work results { } Hospital records { } Assessments { } Other I understand that treatment and coverage is not based upon my signing this authorization. This information is needed for the following purposes: { } To provide on going treatment/aftercare. { } At the request of the patient (or parent/legal guardian { } Other _____
Step 4:	I understand this authorization is subject to revocation at any time unless action based on it has already begun. Requests for revocation will be done in writing. The authorization expires 90 days from the date of signature. I understand that the information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I further release the persons and/or agencies named above from any liability arising from the release of this information to such persons and/or agencies, provided the said release of information is done substantially in accordance with the applicable law. Authorization does not include psychotherapy notes, information protected under Fed. Reg. 42 CFR Part II or HIV information unless authorized. **{ } I DO { } I DO NOT** agree that a copy of this form is valid as the original. Date: _____ Signature of patient_____ Signature of legal guardian or parent of patient under 18 _____/_____ Relationship to patient
Step 5:	**AUTHORIZATION TO RELEASE HIV INFORMATION** (if not applicable leave blank) I herby specifically authorize the release of HIV (HTLV III) antibody or antigen testing or records containing **HIV, HIV VIRUS** or any **AIDS** related conditions. Signature _____ Date: _____