

Patient's Name:	Date of Birth:
Address:	Telephone Number:

Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From: Name: _____ Address: _____ _____ FAX Number: _____ Telephone Number: _____	To: Name: _____ Address: _____ _____ FAX Number: _____ Telephone Number: _____
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Reason for the Information Transfer Request, (please check):

Transfer to New Primary Care Physician
 Transfer to another OBGYN Office
 2nd Opinion
 Moving
 Insurance
 Legal Matter
 Personal

A copying service fee will be charged for records that are sent directly to a patient.

Information to be released for treatment dates: From ___/___/___ through ___/___/___

Documents to be released: Please check YES or NO for each of the following options:

YES	NO	
		Office Notes
		Laboratory Reports
		Pathology Reports
		Radiology Reports

YES	NO	
		Operative Report
		Medical Records Abstract (all records for last 3 yrs)
		Entire Medical Record

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record and **WILL NOT** be released unless you indicate your specific authorization by **INITIALING** each appropriate category.

Abortion
 Behavioral/Mental Health
 HIV/AIDS Results/Treatment
 Alcohol/Drug Abuse
 Domestic Violence
 Rape/Sexual Assault
 Genetic Testing
 Sexually Transmitted Diseases

Please confirm that you have INITIALED all categories of information that you would like released.

I understand and agree that:

<ul style="list-style-type: none"> ● The information which I authorize for release may be re-sent and is no longer protected by federal privacy regulations. ● I will be charged a fee for information that is sent directly to me. ● I decline the opportunity to inspect or copy the information released. ● I have received a copy of this authorization 	<ul style="list-style-type: none"> ● I may take back this authorization at any time by notifying the physician / hospital / clinic / organization from whom I am requesting this information in writing provided that the information has not already been released. ● This authorization is voluntary. ● My treatment will not be conditioned on the completion of this authorization. ● My questions about this authorization form have been answered.
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This authorization expires 90 days from the date it was signed OR as specified: ___/___/___

X _____ or X _____
 Patient's Signature Person authorized to sign for patient Relationship to patient

Date: ___/___/___ Time: _____

Provider Initials: _____ Date: _____ OK to send: _____ Service Fee Charge: _____