Stoneridge Obstetrics & Gynecology

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient name: ______________________ Date/time request received: ______________________

Patient address: ______________________

Date of birth: ______________________ Patient phone: ______________________

I authorize: ______________________

To release my medical records to: ______________________

Address and/or fax#/phone of the recipient or where my health information should be delivered:

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Specific information to be released: ______________________

Dates of service from: ______________________ to: ______________________

Specific purpose of release: ______________________

Note: At the request of the patient, it is sufficient if the patient is initiating this authorization.

HIV, behavioral health, and drug and alcohol treatment contained in the parts of the record(s) indicated above will be released through this authorization unless I request otherwise by checking here: ____

Exception: I do not give permission to release (please specify): ______________________

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I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I acknowledge that the information disclosed pursuant to this authorization my be subject to redisclosure by the recipient.

I understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the proposes for which it is given unless revoked by me.

I understand that my authorization will remain effective for a period of 90 days from date of my request.

Patient's signature: ______________________

Date: ______________________ Signature of witness: ______________________

If individual is unable to sign this authorization, please complete the information below:

Name of guardian/representative: ______________________ Legal relationship: ______________________

Date: ______________________ Witness: ______________________