MID-CITY OB·GYN

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read carefully before signing and dating. All sections must be complete to be HIPAA compliant.

**1. Patient Name:** _____ **Birthdate:** _____
(PLEASE PRINT) LAST FIRST M.I.

Have you ever used another name (*maiden, adopted, nickname, etc.*)? ❒ No ■ Yes _____

**Address:** _____

**SSN: (last 4-digits)** _____ **Phone#(s):** _____

**2. INFORMATION TO BE RELEASED *BY*:**
INDICATE EACH SPECIFIC CLINIC OR PROVIDER

ORGANIZATION, CLINIC OR PROVIDER

STREET ADDRESS

CITY, STATE, ZIP

PHONE FAX

**3. INFORMATION TO BE RELEASED *TO*:**
REQUEST MUST HAVE COMPLETE ADDRESS

ORGANIZATION, DOCTOR OR NAME

STREET ADDRESS

CITY, STATE, ZIP

PHONE FAX

**4. INFORMATION AUTHORIZED TO RELEASE (Choose only one)**

❒ **ALL MEDICAL RECORDS/DATES**

❒ **Medical Record for following dates:** _____ THRU _____

❒ **Specific Information:** _____

**5. PURPOSE:** ❒ PERSONAL ❒ TRANSFER OF CARE ❒ CONTINUATION OF CARE

Other: _____

**Note:** There will be a fee for processing medical records, which will vary based on the delivery method (fax, email, or USB), unless records are sent directly to another healthcare provider. Contact our office for more information.

**6.** This authorization will be valid for 365 days from the date it is signed or until _____, whichever is shorter.

This authorization may be revoked at any time by notifying the above-named provider of information, in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Mid-City OB-GYN and its affiliates cannot condition treatment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. This may include records created after the date of signature, if not expired.

**7. INFORMATION PROTECTED BY STATE AND FEDERAL LAW**

I understand that the information released from my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or gene related impairments, including genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby authorized to release all information/records related to such diagnosis, testing, treatment, unless specifically excluded on the line below:
EXCLUSIONS: _____

**8. METHOD** (Choose One): ❒ Uploaded to Password Protected USB: **Choose One:** ❒ Mail to home address ❒ Pick up in office

❒ Email via secure portal (add email address below)
email address: _____

I understand emails can be intercepted, altered, forwarded, or used without authorization. Emails can be circulated, forwarded, and stored in both electronic and paper formats. Email addresses can be incorrectly written or typed. Emails can be inadvertently exposed and lost during creation and transmission due to technical failure. I understand and accept the risk of using an unsecure email. I agree for Mid-City OB-GYN to email instructions on how to retrieve my protected health information when the email delivery method is chosen. I fully understand the risk involved in using the email delivery method for said access to my protected health information.

**9. LEGAL SIGNATURE:** _____ **DATE:** _____
Parent/Legal Guardian must sign if patient is a minor.: NE under age 19; IA under age 18 **Required: Attach Legal Documentation (POA, guardianship)**

**10. PRINTED NAME:** _____

***11.*** *If other than self, relationship to the patient:* _____