AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)

Patient Name: _____ Date of Birth _____

Address: _____ City/State/Zip: _____

Phone: H) _____ W) _____ C) _____ SS#: _____

RELEASE FROM: (Name of physician or facility releasing information)

I authorize release of my medical record from:

NORTHWEST OBSTETRICS & GYNECOLOGY ASSOCIATES, INC
3841 Trueman Court
Hilliard, OH 43026
Phone 614-777-4801 Fax 614-777-8644

RELEASE TO: (Name of physician or facility receiving information)

Please send my medical record to:

Physician/Facility: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED

Please release the following (check all that apply):

[ ] X-ray reports [ ] Lab reports [ ] Hospital reports [ ] 2 years prior from last date seen

[ ] Specific dates: _____ [ ] Specific Information Requested: _____

Reason: [ ] Change of insurance [ ] Transfer of care [ ] Moving out of area [ ] Referral
[ ] Personal file [ ] Legal [ ] Other _____

RESTRICTIONS: Only medical records originated through Northwest Obstetrics & Gynecology Associates, Inc. (NWOB) will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that if the person or entity who received my protected health information is not covered by the Federal Health Care Privacy regulation, the personal health information disclosed may be re-disclosed to another person or entity and t will no longer be protected by the Federal Health Care Privacy Rules. I understand that NWOB may receive compensation for the disclosure of my protected health information. I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain health care treatment from NWOB, payment for this treatment, or my ability to enroll in a health care plan or be eligible for health care benefits. I understand that I have the right to revoke this authorization at any time, in writing, by notifying NWOB's Privacy Officer, except to the extent that NWOB has relied upon this authorization.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient's Signature/Legal Representative: _____

Relationship to Patient: _____ Date: _____