southdale obgyn

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION/ PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

Patient Name (Last, First, M.I.) ____________________ Date of Birth ____________________

Previous Last Name(s) ____________________

Home Phone ____________________

Street Address ____________________

City ____________ State ____________ ZIP code ____________ Other Phone (work or cell) ____________________

INFORMATION RELEASED FROM			INFORMATION RELEASED TO		
Name of Clinic			Name (hospital, clinic, attorney, insurance company, individual)		
Street Address			Street Address		
City	State	ZIP Code	City	State	ZIP code
Phone	Fax		Phone	Fax	

INFORMATION TO BE RELEASED (mark all that apply):

- ❑ All medical records, excluding Radiology Films
- ❑ Records about specific condition: ____________________
- ❑ Other (please specify): ____________________
- ❑ Radiology Report(s)
- ❑ Visit Notes
- ❑ Immunization Records
- ❑ Laboratory Report(s)
- ❑ Hospital Records

DATES OF INFORMATION TO BE RELEASED:

- ❑ Specific date of service: ____________________
- ❑ Other (please specify): ____________________
- ❑ All clinic records
- ❑ Last 2 years
- ❑ Last 1 year
- ❑ Last 6 months

All records regarding mental health and/or HIV related illnesses will be released unless indicated here:

- ❑ **DO NOT RELEASE RECORDS RELATED TO MENTAL HEALTH AND/OR HIV**

REASON FOR RELEASE OF INFORMATION:

- ❑ Transfer of care (Explain below)
- ❑ Concerns about care (Explain below)
- ❑ Other (Explain below)
- ❑ Health Insurance
- ❑ Legal/Litigation
- ❑ Second Opinion
- ❑ Personal use
- ❑ Moving out of the area
- ❑ Referral for medical care

Explain ____

Authorization expiration date or event: ____________________ (If left blank, authorization will expire one year from date of signature.)

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Southdale OB/GYN Consultants will not refuse or restrict my treatment if I choose not to sign this Authorization. A photocopy/fax/scanned image of this authorization will be treated in the same manner as an original. Further, I realize that Southdale OB/GYN Consultants cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Southdale OB/GYN Consultants is released from any and all liability resulting from redisclosure.

Signature of Patient ____________________ ____________________

Signature of Parent/Legal Representative ____________________ Date ____________________

Southdale Obstetric & Gynecologic Consultants

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