Heartfelt
OBSTETRICS & GYNECOLOGY

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Authorization to Release Protected Health Information

A.) Patient Information:

Full Name _____ Maiden Name _____ Date of Birth _____

SSN _____ Address _____ City/State/Zip _____

Home Phone Number _____ Cell Phone Number _____ Email Address _____

B.) I hereby authorize to:

☐ Release records **to**: ☐ Receive records **from**:

Individual/Facility/Agency _____

Address _____

City/State/Zip _____

Phone Number _____

Fax Number _____

Email Address _____

C.) Protected Health Information to Release

Date Range: _____ to _____ ☐ **All Dates**

- ☐ All Records
- ☐ Physician Office Notes
- ☐ Radiology/X-Ray/MRI Reports
- ☐ Operative Chart Notes
- ☐ Labs/Pathology
- ☐ Ultrasound/Imaging
- ☐ Other: _____

D.) For the Purpose of:

- ☐ Insurance/ Aflac
- ☐ Self/Personal Copy
- ☐ Continuity of care
- ☐ Transfer of Care (Permanently leaving)
- ☐ Other

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization.

I understand that the information in my medical records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization , I must do so in writing and present my written revocation to the Medical Records Coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization pertains to records for dates on or prior to my signed records request. A new records request will be necessary for future records.

_____ _____

Signature of Patient (If under the age of 12, Parent/Legal Guardian) Date