Metro OB/GYN, LLC

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

(Please provide all information requested. If information is missing or not legible, then authorization is not valid.)

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: (____) _____ Previous Name: (if applicable): _____

I hereby authorize _____
(Facility/Provider Name and address)

To release information from the medical record of: _____
(Patient Name)

To: _____
(Name/Address of person or organization to which disclosure is to be made)

Fax Number: (____) _____ Telephone Number: (____) _____

Release the following information:

____Records from last ____year(s), including notes, Lab and X-rays.

____Lab report date(s): _____

____X-ray report date(s): _____

____Progress notes date(s): _____

Other: _____

For the following purpose:

_____Legal _____Insurance ____Patient Request

Other: (please explain)

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby authorize the release of data and information relating to: (check any that apply)

_____HIV/AIDS related testing _____Mental Health _____Chemical Dependency (Drug/Alcohol)

This authorization will be valid for 180 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. Metro OB/GYN and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

_____ _____
Signature of Patient or Legal Guardian/Date Relationship to Patient, if not the patient
(Parent/Legal Guardian must sign if patient is a minor: NE under age 19, IA under age 18)