

Altoona Ob/Gyn Associates, Inc.

Patient Authorization to Release Medical Records

I _____ DOB: _____
(Patient Name.)

_____ SS# _____
(Patient Address.)

authorize _____
(Name of Physician, Practice, Facility, etc.)

to provide _____
(Name of Physician, Practice, Facility, etc.)

(Address of Physician, Practice, Facility, etc.)

The information to be released is (state specific documents, time period, etc.):

Purpose or need for the information requested:

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed.

Whether I sign or refuse to sign, my treatment will not be affected.

General Authorization:

I understand also that I may revoke this authorization, in writing at any time except to the extent that action has been taken in reliance thereon. This consent will remain in effect no more than ninety (90) days from the date I signed this Authorization in order to accomplish its purpose.

Patient/Parent/Legal Guardian Signature _____ Relationship _____ Date _____

Witness Signature _____ Date _____

Special Authorization:

I understand that my medical records may contain alcohol/drug abuse, mental health information, HIV results, and/or STD testing results. I give special authorization to the health care provider/facility to release this information to the person, physician, facility named above for the stated purpose.

I have read this form, or had it read to me and understand the content. I was given the opportunity to ask questions and have them answered to my satisfaction,

Patient/Parent/Legal Guardian Signature _____ Relationship _____ Date _____

Witness Signature _____ Date _____

If signed by other than patient, state relationship and reason for patient's inability to sign.
