ALTOONA OB/GYN ASSOCIATES, INC.

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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 in my records 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.

_____