# THE OB-GYN PLACE

**A PROFESSIONAL ASSOCIATION**

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**GYNECOLOGIC SURGERY & OBSTETRICS**

## AUTHORIZATION FOR RELEASE OF INFORMATION OTHER THAN RELATED TO TREATMENT, PAYMENT, AND OPERATIONS (TPO)

I authorize The OB-GYN Place to disclose my individually identifiable health information as described below, including but not limited to information concerning communicable diseases such as (HIV) and (AIDS), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal and State privacy regulations. I also understand that I will be responsible for the cost of producing and delivering the requested information.

PRINT PATIENT NAME ______ DATE OF BIRTH ______ SOCIAL SECURITY # ______

REQUESTER'S ADDRESS (STREET, CITY, STATE, ZIP) ______

Please specify information to be released (check ALL that apply)

Date(s) of Visit(s)/Specific date(s) of requested information: ______

___Registration information
___Progress /Nurse's notes
___Physician's orders
___Laboratory reports
___EKG reports
___Radiology reports
___Consultation reports
___Immunization records
___Non-Stress Test results
___Sonogram reports
___Billing Records
___History & Physical Exam
___Discharge Summary
___Mammogram reports
___Bone Density reports
___OTHER______

PURPOSE for use/disclosure: ______

The specified health information shall be released to: ___Patient ___Insurance Company ___Hospital ___Physician ___Attorney ___Relative

___Other (specify) ______

______

NAME (to whom records will be released and delivered to) ADDRESS (Street, City, State, Zip)

**I understand that the expiration date of the Authorization is (30) days from the date on this form unless otherwise specified: __________, whichever occurs earlier.**

**Expiration Event/Date**

**I further understand that I may REVOKE this authorization at any time by written and signed notification to The OB-GYN Place. The written revocation must be dated with a date that is later than the date of the this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. There is a Minimum Processing fee of $25.00.**

SIGNATURE OF PATIENT OR PATIENT'S AUTHROIZED REPRESENTATIVE ______ DATE ______

PRINTED NAME ______ PHONE NUMBER ______

RELATIONSHIP OR STATUS IF SIGNED BY ANYONE OTHER THAN PATIENT ______

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