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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME: _____ DATE OF BIRTH: _____
Please print *MM/DD/YYYY*

FROM: Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the following provider:

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE: () _____ FAX: () _____

TO: To disclose to the party listed below:

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE: () _____ FAX: () _____

WHAT: The following protected Health Information:

ALL MEDICAL RECORDS GENERATED AT OFFICE, INCLUDING INFORMATION REGARDING THE FOLLOWING CONDITIONS

(INITIAL THOSE CONDITIONS TO BE INCLUDED):

- SUBSTANCE ABUSE PSYCHOLOGICAL CONDITIONS
 HIV/AIDS BILLING INFORMATION

ALL MEDICAL RECORDS GENERATED AT OFFICE DURING DATES FROM _____ TO _____
MM/DD/YYYY *MM/DD/YYYY*

ONLY RECORDS AS SPECIFIED: _____

WHY: MOVING OUT OF AREA CHANGING PHYSICIANS 2ND OPINION SPECIALTY CARE

I understand this protected Health Information is being used by the facility for the purpose of providing healthcare or to pursue and receive reimbursement of claims from any and all responsible third parties, as allowed in the subscriber's health plan or insurance policy. This authorization shall be in force and remain in effect for 1 year from the date signed below unless I indicate otherwise.

I understand that, as set forth in the Privacy Notice, I have the right to revoke this authorization in writing at any time by sending written notification to Capital OB/Gyn. I understand that my revocation of this authorization will not affect any actions taken by Capital OB/Gyn in reliance on this authorization prior to the time it received my revocation. I understand that I have the right to receive a copy of this authorization upon request.

➔ SIGNATURE _____ DATE _____
MM/DD/YYYY

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP AND AUTHORITY: _____

PRINTED NAME OF PERSONAL REPRESENTATIVE: _____