REQUEST FOR COPY OF MEDICAL RECORD &

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO OTHERS

PATIENT Last Name ______________________________ First ______________________ MI ____

Maiden or Other Name __________________________ DOB______________

Address ______________________________ CITY ______________ STATE ____ ZIP ________

Home Phone __________________ Cell Phone ________________

I hereby authorize ______________________ to release my health information to: Lawrence OB/GYN Associates

0 Secure electronic delivery to fax #: 609-896-3986

0 Paper copies sent via mailing address: 123 Franklin Corner Road, Suite 214, Lawrenceville, NJ 08648

INFORMATION TO BE DISCLOSED:

0 Complete Record

0 Labs, X-Rays, & tests

0 From ______________ to ____________

0 Other: ____

The information to be disclosed to and used by the above is for the following purpose:

0 Personal use by patient 0 Continuing Care 0 Attorney/Legal 0 Other

0 Moving 0 Transferring out of Practice

I understand that the information to be disclosed includes my identity, diagnosis and treatment including **ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV** information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________________

If legal representative, please sign below, state relationship, authority to do so and attach the document of authority.

SIGNATURE- LEGAL REPRESENTATIVE: ________________ Date: ____________________

PRINT NAME-LEGAL REPRESENTATIVE: ________________ Relationship: _____________