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 Lawrence OB/GYN Associates to release my health information to: _____

0 Secure electronic delivery to fax #: _____

0 Paper copies sent via mailing address: _____

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 Reason_____

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 I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Lawrence OB/GYN Associates at the address listed above. I understand that this revocation will not apply to the extent that the practice has already taken action in reliance on this authorization. **This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:** _____

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: _____

For in-office use only

Received on _____ Completed on _____

Received by _____ Completed by _____