

South Denver

Obstetrics and Gynecology, PC



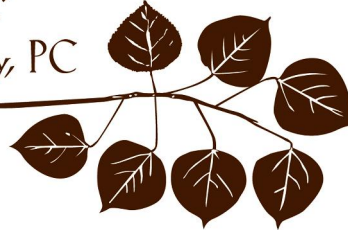
Release of Medical Records

For quality assurance within our practice, we would appreciate your assistance in providing the reason for the release of records.

Thank you,
South Denver OB/GYN

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South Denver Obstetrics and Gynecology
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AUTHORIZATION TO RELEASE HEALTH INFORMATION

RECORDS REQUESTED FROM:

Name of Organization: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone Number: _____
Fax Number: _____

Patient Name: _____ Date Of Birth: _____

My Authorization:

You may disclose the following health care information (check all that apply)

_____ All of my health care information maintained by the above named practice

Circle the following that apply

- Include or Exclude My health information related to drug abuse
Include or Exclude My health information related to alcohol abuse
Include or Exclude My health information related to HIV/AIDS
Include or Exclude My health information related to psychiatric conditions/psychotherapy notes

_____ My health information relating to the following treatment or condition

_____ My health information for date(s) _____

You may disclose my information to:

Name of Organization: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone Number: _____
Fax Number: _____

Reason(s) for this authorization (check all that apply)

At my request _____ Other (specify) _____

This authorization ends: _____ OR when the following event occurs _____

My Rights

I understand I do not have to sign this authorization form in order to get healthcare benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

· To take part in a research study

· To receive healthcare when the purpose is to create health information for a third party

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

· Fill out a revocation form. The form is available from the office OR write a letter to the office

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature _____

Patient Printed Name _____ Date _____

Relationship to Patient _____