Obstetrical & Gynecological Associates, Inc. We Understand Women.

85 E US HWY 6, SUITE 330
VALPARAISO, IN 46383-8947
Phone: (219) 462-6144, Fax: (219) 465-1150

Authorization for Release of Health Information

Patient Name _____ Phone Number _____

Address _____ Date of Birth _____

_____ Social Security # _____

I hereby authorize that the protected health information regarding this person above be received from/sent to:

From or to: (please circle)

Obstetrical & Gynecological Associates
85 E US Hwy 6, Suite 330
Medical Office Building, 3rd Floor.
Valparaiso, IN 46383
medrecords@weunderstandwomen.com
Fax (219) 465-1150

From or to: (please circle)

Person/Institution _____

Address _____

_____

Phone number _____ Fax number _____

Purpose/Need for information: _____

- o ALL Records
- o Emergency Department Report
- o History & Physical
- o Progress Note/Physicians' Note
- o Laboratory/Pathology Report
- o X-ray/Radiology/Diagnostics reports
- o Operative reports
- o Consultation reports

Records for the time period (Dates): From _____ to _____

I must check one or more of the following types of health information that I do **not** want released. I understand that if I do not check any of the three boxes, this information may be included:

- o Diagnosis, evaluation and treatment of alcohol or drug addiction or abuse.
- o Records of HIV test results, diagnosis, and treatment.
- o Psychiatric or psychological records of diagnosis, evaluation, and treatment of mental Illinois disorders.

Signature _____ Date _____

Witness _____

I understand that this authorization is subject to revocation or withdrawal by me at any time in writing to the OGA medical records department. This authorization shall remain valid unless revoked but will expire one year after signing.