Obstetrical & Gynecological Associates, Inc. We Understand Women.

85 E. US Highway 6, Suite 330
Valparaiso, IN 46383
219-462-6144
Fax: 219-465-1150

Patient Name _____ Phone Number _____
Address _____ Date of Birth _____
_____ Social Security #_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

From: Person/Institution:_____
Address:_____
City_____ State_____ Zip_____
Phone_____ Fax _____

To: (Recipient)
Obstetrical & Gynecological Associates, Inc.
85 E. US Highway 6 , Suite 330
Valparaiso, IN 46383

Purpose or need for information:_____

- ☐ ALL RECORDS
- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ Emergency Report
- ☐ History & Physical
- ☐ Progress/Physician Notes
- ☐ Nurses Notes
- ☐ Laboratory Report
- ☐ X-ray/Radiology Report
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Other: _____

Records for the period (Dates): From: _____ To:_____

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient will included any of the following:

_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse

_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment

_____ Psychiatric, psychological records or evaluation an/or treatment for mental, physical, and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will to refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____
Signature of Patient/Responsible Party Date

_____
Witness

REDICLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Obstetrical & Gynecological Associates, Inc cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby give to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.