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 be received from/sent to:

From/To:

Obstetrical & Gynecological Associates
85 E. U.S. Highway 6, Suite 330
Medical Office Building, 3rd Floor
Valparaiso, IN 46383
Fax 219 465 1150

From/To:
Person/Institution:_____
Address:_____
_____
Phone:_____Fax:_____

Purpose/Need for information:_____

- ALL RECORDS
- Emergency Department Report
- History & Physical
- Progress Notes/Physicians' Notes
- Laboratory/Pathology Reports
- X-ray/Radiology/Diagnostic Reports
- Operative Reports
- 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:

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

Signature_____Date_____
Witness_____

I understand that this Authorization is subject to revocation or withdrawal by me at any time in writing to the medical record contact person at this site. This Authorization shall remain valid unless revoked but will expire one year after signing.

Obstetrical and Gynecological Associates, Inc.
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