

OB-GYN Associates of Montgomery, P.C.
495 Taylor Road Montgomery, Alabama 36117
Phone # (334) 279-9333 Fax # (334) 279-9057

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(PLEASE ALLOW 2-4 WEEKS FOR REQUEST TO BE PROCESSED)

PATIENT: _____ DOB: _____ LAST 4 OF SOCIAL: _____

ADDRESS: _____ PHONE#: (_____) _____

CITY: _____ STATE: _____ ZIP: _____

I am requesting that _____
(Physician, Hospital, Clinic, Lab, Radiology or other Healthcare Provider that you want to release your records)

located at _____

CITY: _____ STATE: _____ ZIP: _____

release my records to: _____
(Who your records are going to)

located at _____

CITY: _____ STATE: _____ ZIP: _____

REASON FOR REQUEST: _____

I am requesting this information be delivered by: _____ MAIL _____ FAX# (_____) _____ PICK UP
(Pt. Initials) (Pt. Initials) (Who is receiving your records) (Pt. initials)

My authorization extends only to those data documents INITIALED below:

- _____ Records of all visits/labs/radiology
- _____ Labs
- _____ Radiology
- _____ Statements of charges or payment
- _____ Hospital
- _____ All of the above
- _____ Other (must be specific) _____

All below are Sensitive Protected Health Information, please initial if you wish this information to be released:

- _____ Mental Health
- _____ Substance Abuse
- _____ AIDS, HIV, Sexually Transmitted Diseases (STD)

This authorization is given freely with the understanding that:

- 1) Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- 2) A photocopy or fax of this authorization is as valid as the original.
- 3) I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one year from the date signed, or sooner if noted below.
- 4) OB-GYN Associates of Montgomery, P.C., its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- 5) Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
- 6) I understand that any disclosure of healthcare information carries with it potential for unauthorized and future re-disclosures, as allowed by HIPPA and other federal privacy rules. If I have questions about my disclosures of my health information, I can contact my provider of care.

PATIENT'S NAME PRINTED

DATE

PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE IF MINOR

EXPIRATION DATE (IF OTHER THAN 1 YEAR FROM DATE ABOVE)

DATE OF BIRTH

WITNESS

***The most recent year of the patient record is copied as a courtesy, otherwise, the patient may be charged a fee for the copies set forth in the following schedule: \$5.00 for research and retrieval, \$1.00 per page for the first 25 pages and \$.50 per page for each additional page. Records are copied inhouse; therefore, you may receive a bill/invoice before records are released.