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 (Pt. Initials) _____ FAX# ( ) _____ (Who is receiving your records) _____ PICK UP (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 form 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.
7.) The patient will be charged for all personal copies of their medical record. Records are copied Inhouse, the patient will 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. If you do not pick up your requested records, you will be billed.

_____
PATIENT'S NAME PRINTED

_____
DATE

_____
PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE IF MINOR

_____
EXPIRATION DATE (IF OHER THAN 1 YEAR FROM DATE ABOVE)

_____
DATE OF BIRTH

_____
WITNESS