

OB/GYN Associates, PA

**AUTHORIZATION TO RELEASE
MEDICAL INFORMATION AND/OR MEDICAL RECORDS**

I, _____ authorize OB/GYN Associates, PA to use or disclose Protected Health Information contained in my medical records in the following manner:

Patient Address: _____

Patient Phone #: _____ Date of Birth: ____/____/____

Release to: _____
(Name of entity or individual to receive information)

Mailing Address: _____
(Address of entity or individual to receive information)

Release the following Protected Health Information: _____

(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information)

The Protected Health Information is being used or disclosed for the following purpose(s): (If the patient is requesting the release, this may be left blank) _____

I understand there may be a fee involved with the release of information.

This authorization is in full force and effect until _____ or until _____
(Date) (List specific event, no greater than 6 months after effective date)

I understand that I have the right to revoke this authorization in writing by sending notification to:

OB/GYN Associates, PA	or OB/GYN Associates, PA	or OB/GYN Associates, PA
Attn: Privacy Officer	Attn: Privacy Officer	Attn: Privacy Officer
3520 E. Louise Drive	315 E. Elm Street, Suite 310	3101 E. State Street, Suite 2100
Meridian, ID 83642	Caldwell, ID 83605	Eagle, ID 83616
(208) 888-0909	(208)454-2035	(208) 938-2220.

I also understand that when I revoke this authorization, it is not effective to the extent that OB/GYN Associates has already relied on the use or disclosure of the Protected Health Information.

I understand the Protected Health Information released prior to this authorization might be re-disclosed by the party who received that information and may no longer be protected by federal or state law.

OB/GYN Associates, PA, will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure. I understand that I have a right to inspect or copy the protected health information to be used or disclosed. I understand that I have a right to refuse to sign this authorization.

If you have any questions concerning this form, please phone.

(Signature of Patient or Personal Representative)

(Date)

(Printed Name of Patient or Personal Representative)

(State authority to act as authorized representative)

(Contact Phone number for follow-up)