

Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical records of:

Patient Name: _____
FIRST MI LAST

Date of Birth: _____ SS#: _____

I authorize the following individual or organization to disclose the above named Individual's health information:

Address: _____
STREET APT# CITY STATE ZIP

This information may be disclosed to and used by the following individual or organization: _____

Address: _____
STREET APT# CITY STATE ZIP

For the purpose of: _____

Please release the following:

- | | |
|--|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> X-Ray/Imaging Reports from ____/____/____ to ____/____/____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Results from ____/____/____ to ____/____/____ |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Genetic Testing Information |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Other Diagnostic Reports (Specify) _____ |
| <input type="checkbox"/> List of Allergies | <input type="checkbox"/> Other (Specify) _____ |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

- Yes, I consent to the release of this information.
- No, I do NOT consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and I must present my written revocation to the individual or organizations releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition this authorization will expire in 6 months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected from federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact Cornerstone Ob-Gyn.

SIGNATURE

DATE

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results and notes only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Cornerstone Ob-Gyn, its staff, or its Providers liable to any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

SIGNATURE

DATE