Partners We care for life

PARTNERS *in* OBSTETRICS *and* GYNECOLOGY

3421 West 9th St. Suite G4500 | Waterloo, IA 50702

Tel: 319-233-8865 Fax: 319-272-0400

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(please complete in full)

I authorize release of my medical records from: To:
(Name and address of previous physician)

_____ _____

_____ _____

_____ _____

For the following patient: *ANYONE 18 YEARS OR OLDER MUST SIGN HER OWN FORM.

PRINT NAME _____ **DATE OF BIRTH** _____

SOCIAL SECURITY NUMBER: _____

_____ Complete record

_____ Physician notes, office visits

_____ Labs, EKG and X-rays

_____ Immunization and growth record

_____ Consultations

STATE AND FEDERAL LAW REQUIRES A YES OR NO ANSWER TO THE AUTHORIZATION FOR RELEASE OF THE FOLLOWING INFORMATION:

If contained within my medical records, the following information may be released:

HIV-related information ☐ Yes ☐ No

Substance abuse information ☐ Yes ☐ No

Mental Health information ☐ Yes ☐ No

This authorization will expire one year from the date of signature.

_____ _____

Signature Date

Spouse:

I authorize my laboratory and consultation results to be added to and released from _____ (patient's name) medical record.

_____ _____ _____

Printed Name Signature Date

Patient authorization for use and disclosure of protected health information

By signing this authorization, I authorize **Partners in Obstetrics and Gynecology** to use and/or disclose certain protected health information (PHH) about me to _____.

This authorization permits **Partners in Obstetrics and Gynecology** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc..)

_____

_____

The information will be used and or disclosed for the following purpose:_____

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The practice will____ will not____ receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I do not have to sign this authorization in order to receive treatment from **Partners in Obstetrics and Gynecology.** I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization. My written revocation must be submitted to the Privacy Officer at:
Partners in Obstetrics and Gynecology
3421 W. 9th St., Suite G4500
Waterloo, Iowa 50702

Signed by:_____ Relationship to Patient:_____

Patient's Name:_____ Date:_____

Print Name of Patient's Legal Guardian:_____

Patient/Guardian to be provided with a signed copy of authorization.