AUTHORIZATION
For The Release of Medical Information

Patient Name: _____ Phone Number: _____

Patient Address: _____

Medical Record #: _____ Date of Birth: ____/____/____
MM DD YYYY

Social Security Number: _____ - _____ - _____

"I hereby authorize Plaza-Towers Ob/Gyn to make uses and disclosure of my protected health information (information pertaining to my medical records and/or financial records) as indicated below."

THIS INFORMATION IS TO BE DISCLOSED TO:

Name: _____ Attention: _____

Street Address: _____

City/State/Zip Code: _____

Phone No: _____ Fax No: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____

_____

For dates of treatment from _____ to _____

REASON FOR REQUESTED USE OR DISCLOSURE:

☐ Transfer of health coverage ☐ Personal Use ☐ Form Completion ☐ Referral ☐ Change in health care provider

☐ Other reason _____

This authorization expires in 6 months from the date signed or earlier _____.
DATE

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so.
e. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
g. I will receive a copy of this completed and signed authorization form.

Medical Records Copying Fees: $25

Patient Signature _____ Date _____

Signature of Patient's Representative _____ Relationship _____ Date _____

Office Use Only: Initials _____ Date Faxed/Mailed/Copied _____