



We care for life

PARTNERS in OBSTETRICS and GYNECOLOGY

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(please complete in full)

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

To:

Three horizontal lines for entering previous physician information.

Three horizontal lines for entering recipient information.

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

Horizontal line for patient name.

NAME

Horizontal line for patient date of birth.

DATE OF BIRTH

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

Mental Health information Yes No

Substance abuse information Yes No

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

Horizontal line for signature.

Signature

Horizontal line for date.

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.