Northern Valley Obstetrics & Gynecology

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name of Patient: _____ Date of Birth: _____ Phone #: _____

Previous Name: _____ Social Security #: _____

I authorize: To release to:

_____ _____

_____ _____

_____ _____

This request and authorization applies to:
__ Healthcare information relating to the following treatment, condition, or dates:

_____
__ All healthcare information

__ Other: _____

Purpose of the use and disclosure

__ Further Treatment (Date of appointment _____) __ Insurance Application
__ Personal Records __ Education __ Disability Determination
__ Vocational Rehabilitation __ At my request __ Payment of Insurance claims
__ Legal __ Other _____

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if not date or event is specified, 12 months from the date of signing.

A photocopy of fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
(If not patient, state authority/relationship)