Authorization for Release of Medical Information (PHI)

Patient Name:______________________________________ Date of Birth____________________________

Street Address:_____________________________________ Social Security #:________________________

City/State/Zip:_____________________________________ Phone::___________________________

_______I, ________________________________ I do hereby authorize Southern Urogynecology to release:

_______I , ________________________________ hereby acknowledge that Southern Urogynecology Is authorized to receive and request medical records as follows:

Dates of Service: ____

Information to be released:

_____Office Notes _____Operative Notes _____Lab Reports _____Pathology Reports
_____History & Physical _____Progress Notes _____Radiology Reports
_____Urodynamics Report _____Cystoscopy Report _____Other
_____Entire Record

_____I do _____I do not authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care, and/or psychological assessments, and treatment for alcohol and/or drug abuse.

RELEASE RECORDS FROM:

____
(Name of Company/Agency/Facility/Person)

Address____ Ph___________________Fax_________________

RELEASE RECORDS TO: ____
(Name of Company/Agency/Facility/Person)

Address____ Ph___________________Fax_________________

PURPOSE OF DISCLOSURE:

_____Continuity of Care _____Legal Investigation _____Workers Comp
_____ Referral to Specialist _____Change of Doctor _____Disability Determination
_____ Insurance _____Personal
_____Other: ____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign

Signature____ Date___________________
Relationship to patient if other than patient:____
Relationship/Reason patient is unable to sign____