



OB-GYN ASSOCIATES, INC.

Authorization for Disclosure of Protected Health Information

I, _____, hereby authorize the release of my health information, as listed below, for purposes of continuing medical care.

Patient name: _____ Date of birth: _____

Address: _____

Telephone: _____

Provider or facility authorized to release information:

Person or entity to receive information:

Dates of Services:

- All
 Specific dates of service: _____

Description of information:

- Entire Record
 Other: _____

Special records: Include the following medical records if such information is included in your records. Checking the boxes does not show that such information exists.

- _____ Include drug and alcohol abuse records.
initial
- _____ Include mental health records.
initial
- _____ Include HIV/AIDS -related records.
initial
- _____ Include sexual abuse/assault and domestic violence counseling records.
initial

Purpose of release of information:

___ MOVING ___ INSURANCE ___ SECOND OPINION

___ OTHER (Please give details/comments) _____

ONE RANDALL SQUARE, PROVIDENCE, RI 02904

401-331-6980

www.obgynassociates.org

Unless otherwise specified, this authorization will expire 6 months after the date of this request.
Date: _____

I understand that I may revoke this authorization at any time by notifying OB/GYN Associates in writing. I understand that revocation will not have an effect on actions taken prior to any revocation. This authorization is voluntary. I understand that these records, once released, are subject to being re-released and will no longer be protected. I understand that if the organization authorized to receive the information is not a health plan or a healthcare provider, the information may no longer be protected by federal privacy regulations.

Final Authorization:

Signature of patient or patient's representative/guardian: _____

Date: _____

Printed name of patient's representative: _____

Relationship to the patient: _____

Signature of witness: _____

Medical Record Release Fee: \$15.00 Retrieval fee plus \$.25 cents per page for the first 100 pages, and \$.10 cents per page after 100. A special handling charge of \$10.00 will be added if needed within 48 hours. Please allow 3-4 weeks to process your request.

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS WILL BE RETURNED.