

OB/GYN RECORDS REQUEST FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I heroby authorize	Patient Name	Date of	f Birth/ Phone #
of my evaluation and/or treatment to: TriState Obstetrics & Gynecology (OB/GYN), ATTN: Referral Coordinator, 1119 Highland Ave, Suite 2, Clarkston, WA, 99403 Phone #: 509.769.2252 Fax #: 509.769.2253 Records Requested - for all patients Wit: Last year of: Labs PCP Notes related to OB/GYN Mammogram Pap Wellness Unless otherwise indicated, I authorize the release of information regarding testing, treatment and diagnosis, to include: alcohol and drug abuse, sexually transmitted infections, HIV/AIDS, genetics and mental/behavioral health, to include psychotherapy notes. (Initial) DO NOT AUTHORIZE TO INCLUDE THE ABOVE SENSITIVE RECORDS IN THIS RELEASE. This authorization is valid until OR when the following event occurs, if left blank, this authorization shall become invalid and expire 180 days after date signed. I understand that: 1. Information disclosed by this authorization may be re-disclosed by the recipient of your records. Such re-disclosure will no longer be protected by this authorization. Federal or State laws may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. 2. I have the right to receive a copy of this authorization and othere may be a charge for the medical records. 3. A copy or facsimile (fax) of this authorization is as valid as the original. 4. My provider may not condition treatment, payment, enrollment, or eligibility for benefits if I choose not to sign this form. 5. I may revoke this authorization in writing at any time. The only exceptions is when my provider has taken action in reliance on this authorization or the authorization was obtained as a condition of my insurance. The information that I am requesting may be sent by U.S. Mail Service and/or electronic facsimile in accordance with the hospital's facsimile (fax) policy. I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated. Pate I. J. Witness S			
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