Medical Records Release/Request Form (*Please complete all blanks*)

We suggest that you keep a set of your medical record you requested. We shall send your medical record to you UNLESS you want us to send it to your doctor, _____ by mail or by fax (please state clearly the doctor's address, phone number and/or fax number).

Please Send to (who) _____ Address _____

City _____ State _____ Zip _____Phone (____) _____ Fax (____) _____

Patient Authorization for Use or Disclosure of Protected Health Information

As required by the Health Portability and Accountability Act of 1996 (HIPAA) and Connecticut Law, this practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize **Obstetrics & Gynecology Associates,** Whittingham Pavilion, Suite G401, 190 W.Broad Street, Stamford, CT 06902-3633 to release health information of patient named below:

Patient Name: (Print please) _____ Date of Birth: _____

(Other names, Maiden name): _____ Last 4-digit of Social Security Number:_____

Address _____City _____ State _____ Zip _____ Phone _____

Dates of Service to Release: _____ OR _____ the entire Medical Record

Reason for release (must be noted on this form) _____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusion (please initial): Drug/Alcohol _____, Mental Health/Psychiatric _____, Sexually Transmitted Disease _____, HIV/AIDS _____, other _____, Description of other exclusion: _____

This authorization is effective this date: _____ through _____(dates must be specified).

Signature: ✕_____Print Name: _____ Date:_____

If this form is completed by someone other than the patient, please print name and address below and check the appropriate box.

Name: _____

Address:_____

I am the __ Guardian __ Conservator __ Other (please specify): _____

I understand that I have the right to receive a copy of this authorization.

Refusal to Sign Authorization

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPPA. The information used or disclosed as described above may be redisclosed by the recipient and no longer protected by HIPPA. However, other state of federal law may prohibit the recipient from disclosing specially protected information, such as abuse treatment information,

HIV/AIDS -related information, and psychiatric/mental health information.

HIPPA Compliant Patient Authorization Rev.10/17/08 lpc

The Connecticut general statutes allows for the charge of 65 cents per page as referenced by section 27c(b).

The office of Obstetrics & Gynecology Associates will copy your medical record at 50 cents per page plus shipping and handling, if any, minimum $5.00 per request. Fees are payable in advance, we accept MasterCard, VISA and DISCOVER.

Please circle one: MasterCard VISA Name on Card _____

Account Number: _____ Expiration _____/_____

Amount $ _____ Signature: _____