OB/GYN Associates of Lancaster, Inc.

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AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION

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

I hereby authorize: _____
(Individual, Medical Practice, Company)

Address: _____

To release to: _____
(Individual, Medical Practice, Company)

Address: _____

A copy of my records which may include treatment for physical and mental illness, alcohol or drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome) and may include the results of an HIV test or the fact that an HIV test was performed. I understand this authorization extends to release of information via US mail, overnight mail, telephone or facsimile transmission, or in person.

The protected health information will be used and/or disclosed for the following purposes:

_____ Continuity of Patient Care

_____ Insurance/Third Party Request

_____ Other _____

Information requested:

_____ All Records

_____ Operative Reports

_____ Lab/Path Reports

Dates requested: _____

_____ Mammogram Reports

_____ Pap Results

_____ Other _____

The information to be released is limited as noted. State "none" if there are no limitations _____. This authorization will expire 60 days from the date of signature. Under the Privacy Rules, I have the right to revoke this authorization, at any time, in writing to Privacy Officer, OB/GYN ASSOCIATES OF LANCASTER, INC., 1532 Wesley Way, Lancaster, OH 43130. However, if I choose to do so, I understand that my revocation will not affect any actions taken before receiving my revocation. I understand there may be a fee for the transfer of these records. I also understand that, if records are disclosed, OB/GYN ASSOCIATES OF LANCASTER, INC. cannot guarantee the released information will not be re-disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Patient's Representative: _____ Date: _____

Relations to Patient: _____