Lake Obstetrics and Gynecology, Inc.
Patient Authorization to Release/Obtain Medical Information

Patient Name (Print) _____ Social Security Number _____ Patient DOB ___/___/___

I authorize Lake Obstetrics and Gynecology, Inc. to use or release/disclose/obtain (circle one) my health information as described below.

Please identify the information to be released/obtained:

☐ My entire record
-OR-
☐ ***Only*** the following information (check appropriate spaces and include other information where indicated):

_____ Problem list
_____ Medication list
_____ List of allergies
_____ Immunization records
_____ Most recent history
_____ Most recent discharge summary
_____ Lab results (please list dates or types of lab tests you would like disclosed): _____
_____ X-ray and imaging reports (please list dates or types of x-rays or images you would like disclosed): _____
_____ Consultation reports (please supply doctors' names): _____
_____ Other (please describe): _____

The identified information will be used for the following purpose:

_____ My personal records
_____ Sharing with other health care providers as needed
_____ Other (please describe): _____

Please initial each item below to indicate your understanding:

____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), abortion and genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____ Fax: _____

Address: _____ Phone: _____

Appointment date/time _____

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date of event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ ___/___/___
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other: _____