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

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

_____ I authorize Lake Obstetrics and Gynecology to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***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/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). 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 or organization:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

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.

Print Name _____ Patient Signature (or Signature of Person Completing Form if Not Patient*) _____ Date ____/____/____

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

Distribution of copies: original to practice, copy to patient, copy to accompany information released _____ Date ____/____/____

4/2016