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Lincoln Center
OBSTETRICS & GYNECOLOGY, P.A.

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FOR OFFICE USE ONLY
☐ *Paper*
☐ *Electronic*
electronic format requested

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient **(PLEASE PRINT)** | Social Security # | Date of Birth

Street Address | City, State, Zip

Maiden or other names used for records | DATE THIS AUTHORIZATION EXPIRES *(If no expiration date indicated Authorization will expire 1-year from the date of signature)*

RELEASE FROM:	**RELEASE TO:**
Name **(PLEASE PRINT)**	Name **(PLEASE PRINT)**
Address	Address
City, State, Zip	City, State, Zip

The following protected health information is to be disclosed: (*please check all that apply*)

☐ Complete health record
☐ Pregnancy Records
☐ Surgical Notes
☐ Other _____

Covering the period from _____ to _____

Unless specifically indicated, only up to the last three years of records will be copied

This request for disclosure of medical records/information is made at my request for **(state reason for disclosure)**:

_____

Protected health information in a designated record set includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements and invoices (this includes all records including records from other health care providers).

I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.

I understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.

I understand that I may revoke this authorization at any time by delivering/mailing a written revocation to Lincoln Center OB/GYN, PA, and that if I revoke this authorization it will have no effect on actions already taken on reliance on this form.

I understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I understand that I may have a copy of this form after I sign it.

I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

Lincoln Center OB/GYN, PA out-sources copying of protected health information to Quality Copy Service.

Patient's Signature: _____ Date: _____

Signature of Personal Representative of Patient: _____ Date: _____

Personal Representative's Relationship/Capacity to Patient: _____

Representative's Address and Phone Number: _____