Oak Hill Gynecology & Obstetrics

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, then complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. *(optional)*
Patient's Address	Requestors Name/Phone Number (if patient is not the requestor):	

PHI Recipient Name: **Oak Hill Gynecology & Obstetrics**
Address: **11373 Cortez Blvd Ste #308**
City/State/ZIP: **Brooksville, Florida 34613**
Phone Number**: (352)592-7315** Fax Number**: (352) 592-7320**

PHI Sender Name:____________________________________
Address: ____
City/State/ZIP: ______________________________________
Phone Number:**(   )**__________Fax Number:**(   )**___________

This authorization will expire on the following: (Fill in the Date or the EVENT, <u>but not both</u>)
Date:____________________________ Event: ____

Purpose of Disclosure: __**<u>Continuity of Care</u>**____

____

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on <u>this</u> authorization. ☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
X All PHI in record		☐ Physician Orders		☐ Demographics	
☐ History and Physical		☐ Laboratory		☐ Rehabilitation Svcs	
☐ Consult Report		☐ Imaging/Radiology		☐ Special Test/Therapy	
☐ Operative Report		☐ Nursing Notes		☐ Itemized Bill/Claims	
☐ Progress Notes		☐ Medication Record		☐ Other:	

1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information __________ (Initial) If not applicable, check here ☐
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

Section C: Signatures (Initial above and sign here)

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:____ Date: _________________

Print Name of Patient's Representative: ________________________________ Relationship to Patient: _____________________________