Obstetrics & Gynecology Specialists P.C. (The Group)
Authorization to Release Confidential Health Information

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Release of Information **From**: Name: _____

Address: _____

City, State, Zip: _____

Phone: _____Fax: _____

Release of Information **To**: Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I am requesting the information checked below to be disclosed:

- ☐ Last Routine Physical
- ☐ Physician Progress Notes
- ☐ Delivery Records
- ☐ Final Discharge Summary
- ☐ Psychiatric Reports
- ☐ Last 1 Year of Medical Records
- ☐ Last 3 Years of Medical Records
- ☐ Past Surgical Records
- ☐ Drug and Alcohol Summary
- ☐ HIV Reports
- ☐ Laboratory Results (specify type or date _____)
- ☐ X-Ray or Imaging Reports such as Ultrasound (specify type or date _____)
- ☐ Other: (please specify) _____

The purpose(s) of the authorization is (are)

- ☐ Shared Medical Care
- ☐ 2nd Opinion
- ☐ Moving out of the Area
- ☐ Personal File
- ☐ Transferring of Care
- ☐ Other_____

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation of refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be re disclosed and will no longer be protected by the regulations. Iowa and/or Federal law provides that I have a right to prohibit re disclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I further understand that the recipient, without further authorization, may re disclose said information to: Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any said persons. I understand this release is valid for 1 year from date of signature, unless revoked in writing by me.

_____ _____

Patient/Guardian Signature **Date**

(if guardian list relationship to patient)

Internal Use: Chart Number _____ Revised 03/2022