WEST END Obstetrics & Gynecology, PC

Authorization to Use, Disclose or Release Health Information

Patient Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____ Telephone:_____

1. I authorize all healthcare providers including Hospitals, ASC's, physicians and non-physician providers, along with any other healthcare entity that has treated, to use, disclose or release the following PHI about the above named patients.

○ Entire record **(including psychotherapy** records if any exist)

○ Entire record **(NOT including psychotherapy** records if any exist)

○ Or **Only** the Following :

- ○ History & physical
- ○ Discharge Summary
- ○ Laboratory results
- ○ Progress notes
- ○ Consultation reports
- ○ Operative report
- ○ Pathology report
- ○ X-Ray imaging report
- ○ Physician orders
- ○ Prenatal Services
- ○ Other_____

I understand that the information to be disclosed may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral mental health services, and treatment or testing for alcohol or drug abuse.

2. I authorized disclosure of the above listed information to: **West End Ob/Gyn, 7601 Forest Ave, Suite 100, Henrico, VA 23229. Phone: 804-282-9479 Fax: 804-282-9619.**
   For the purpose of :
   - ○ **Continuity of Care**
   - ○ **Changing Physicians**
   - ○ **Moving**
   - ○ **Personal**
   - ○ **Insurance**
   - ○ **Disability**
   - ○ **Other**_____
3. I understand that I have a right to revoke this authorization, in writing, at any time by presenting my written revocation to the address listed in paragraph 3, or other designated representative, at WEOBGYN. I understand that a revocation will not apply to information that has already been released under this authorization. I understand that the revocation will not apply to my insurance company when the law gives my insurer the right to consent a claim under my policy number.
4. **Unless I revoke it sooner this authorization will expire on the following date, event, or condition:**
   - ○ **1 year from the date signed.**
   - ○ **Other:** _____

(Please check one)

_____ **Requesting** my medical records from : OR _____ Please **Send my medical** information to:

Physician/Company **Address** **Phone/Fax**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment. However, information will not be released to the above indicated organization without my signature. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which is in the US code of Federal Regulation section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact WEOBGYN at 804-282-9479.

_____ /____/____
(Signature of Patient or Legal Representative) (Printed Name) (Date)

Relationship to Patient if Legal Representative_____

******THERE IS A $35.00 CHARGE FOR TRANSFERRING YOUR MEDICAL RECORDS******