



ADVANCED OB-GYN ASSOCIATES

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www.advancedobgynassociates.com

WM Richard Salter, MD, FACOG Anu Gupta, MD, FACOG

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all the following elements must be completed for authorization to be valid.

Patient Name: _____ Date of Birth: _____

Previous Name: _____ S. S. Number (optional): _____

I hereby request and authorize: (Circle Your Physician)

WM Richard Salter MD Anu Gupta MD

To release the protected healthcare information on the patient named above to:

Person/Organization: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____ Fax Number: _____

This request and authorization apply to: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> All Healthcare Information | <input type="checkbox"/> Most Recent Progress Notes |
| <input type="checkbox"/> Pathology and/or Lab Reports | <input type="checkbox"/> Date Range (___/___/___ to ___/___/___) |
| <input type="checkbox"/> Other _____ | |

Purpose of Request: Referral Transferring Care due to: _____ Other

- I understand I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration of this Authorization will be ninety (90) days from the date of signature.
- I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (Aids Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (Aids Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment.
- I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, the organization named above will not release my health information.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Re-disclosure: Notice is hereby given to the patient or legal representative signing this Authorization that the company completing this request cannot guarantee that the recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.

Signature of Patient/Guardian/Representative: _____

Relationship to Patient: _____ Date: ___/___/___