green valley ob/gyn

Authorization for REQUEST of Medical Records

_____ _____

Patient's Name (print) **Date of Birth**

_____

Street Address **City** **State** **Zip Code**

_____

Phone Number

I do hereby authorize: _____

Name of Facility

_____

Address **City** **State** **Zip Code**

_____ _____

Phone Number **Fax Number**

To Release (check all that apply): _____ **Mammogram Images CD & Report**

___ I do ___ I do NOT **Authorize release of information related to AIDS (acquired immunodeficiency syndrome or HIV (human immunodeficiency virus) infection, sexually transmitted disease(s), psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.**

Send Records to: **Green Valley Ob/Gyn** **(336) 378-1110** **336-378-9986**

Name of Facility **Phone Number** **Fax Number**

719 Green Valley Road, Suite 201 **Greensboro, NC** **27408**

Address

Attn: Mammography Department

Purpose of Disclosure:

__Referral to Specialist **__Insurance** **__Legal Issue** **__Disability**
__PCP/Internist **__Personal** **__Change of Provider** **__Worker's Compensation**
__Other: _____

I do hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of Patient or authorized representative **Date**