green valley ob/gyn

Authorization for RELEASE of Medical Records

_____ _____

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

_____

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

_____

Phone Number

I do hereby authorize: **Green Valley Ob/Gyn**
719 Green Valley Road Suite 201
Greensboro, NC 27408
(336) 378-1110 Telephone **(336) 378-9986 Fax**

To Release (check all that apply):

___ Entire Record ___ Lab Reports: specify, if needed_____) ___ Hospital Records
___ Pap Smear ___ Pathology ___ Ultrasound ___ Office Notes ___ Mammogram report
___Mammogram Images (CD) & Report ___ Bone Density ___ Other: _____

___ 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: _____

Name of Facility/Agency/Person

_____

Street Address

_____

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

_____

Telephone Number **Fax Number**

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**