AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
PRINT PATIENTS FULL NAME DATE OF BIRTH

_____ _____
STREET ADDRESS CITY

_____ _____
STATE, ZIP PHONE NUMBER

Release Information **FROM**:

Laurel OBGYN
41 Oakland RD, STE 200
Asheville, NC 28801
(828) 253-9087

___ HISTORY AND PHYSICAL ___ LAB RESULTS ___ BONE DENSITY
___ PROGRESS NOTES ___ RADIOLOGY REPORTS ___ ER NOTES
___ OTHER _____ _____
_____ _____

Release Information **TO**:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____
Fax Number

_____
**Email

**When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account. By requesting that we email your Personal Health Information (PHI) you understand that Laurel OBGYN, P.A is not responsible for breach notification or liable for disclosures that occur in transit.

PURPOSE OF DISCLOSURE:

___ REFERRAL TO SPECIALIST ___ INSURANCE ___ WORKERS COMP ___OTHER
___ LEGAL INVESTIGATION ___ PERSONAL ___ DISABILITY DETERMINATION
___ CHANGE OF DOCTOR

I hereby authorize disclosure of the health information for the above patient. I authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. 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 notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individuals or guardian or Personal Representative of patient's estate **Date**

Federal and state laws permit a fee to be charged for the copying of patient's records. This fee is based on a per page amount. Laurel Ob-Gyn will contact you and let you know how much your fee is before we send them out.*

OFFICE USE ONLY AMOUNT CHARGED $_____ *** PAID CA/CHK#_____/CC***INTINALS_____