



Wendover OB-GYN & Infertility, Inc.

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Phone 336-273-2835 • Fax 336-274-4594
www.wendoverobgyn.com

Authorization to Disclose Protected Health or Billing Information Request

I give Permission to release the health information of:

Patient Name _____ DOB _____

Street Address _____

City, State, Zip Code _____ Phone # _____

Release Information:

From	To
Name _____	Name _____
Address _____	Address _____
Phone # _____	Phone # _____
Fax # _____	Fax # _____

Purpose of Release (check reason): Request of individual/personal Insurance Disability
 Transfer Legal Continuation of Care Other: _____

Please Send (check appropriate box):

- All Records (including visits/imaging/labs) Specific Date(s) of Service _____ to _____
- Office Notes _____ Specific Imaging _____
- Specific Labs _____ Other _____

I understand that I am authorizing the release of all medical information from my medical record unless specifically restricted as indicated below (you must initial if you want any restrictions, no check marks):

____ HIV/AIDS or related testing ____ Mental Health ____ Chemical Dependency (drug/alcohol)

This authorization is valid for 180 days from the date signed or until _____ whichever is shorter. This authorization may be revoked at any time by notifying Wendover OB-GYN in writing, except when this authorization was obtained as a condition of acquiring life insurance coverage. Information used/disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected.

Signature of Patient or Legal Representative

Date

Print Name

Relationship of Representative to Patient

Relationship to Patient, if not the Patient

E-mail to: medrec@wendoverobgyn.com (not a secure e-mail) or fax to: 336-274-4594