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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION FROM _____ AT VISALIA OB/GYN MEDICAL ASSOCIATES

Patient Name _____ Birth Date _____

Information to be released **to**:
Name/Agency: _____

Address: _____

Phone: _____ Fax: _____

Purpose and limitations for release: On-going medical care or _____

Information to be released: _____

_____

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires in 1 year or on _____. I realize that this is a required authorization and that I must voluntarily and knowingly sign this authorization before any records can be released. I understand that information used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations. I release my physicians, the clinic/hospital or school, or other entity as identified above and their employees from any liability arising from the release of information from Visalia OB/GYN.

I have a right to receive a copy of this authorization, and I will ask for a copy if so desired. Copy received _____

Signature of Patient _____ Date _____

Signature of Guardian _____ Date _____

Relationship to patient _____