# Authorization for Release of Protected Health Information

Mt Olympus Obstetrics & Gynecology

| Patient Name: | Date of Birth: |
|---|---|
| | |

**This authorization is to release the health information to:**

| Name: | Phone: | Fax: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |

**This authorization is to release the health information from:**

| Name: | Phone: | Fax: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |

**Requested Records:**

- ☐ All Records
- ☐ Records dated:_____
- ☐ Provider Visit Reports
- ☐ Operative Report
- ☐ Pathology and Laboratory
- ☐ Imaging/Radiology
- ☐ Other:_____

**Purpose of Disclosure:**

**I acknowledge and understand:**

1. That the released information may contain alcohol, drug abuse, psychiatric, HIV or AIDS testing and results.
2. That I may refuse to sign this form and it is strictly voluntary.
3. If I do not sign this form, my health care and payment for my health care will not be affected.
4. I may revoke this authorization at any time in writing, but if I do not, it will not affect any action taken prior to receiving the revocation.
5. I understand that I may see a copy of the information described in this form or, for a reasonable fee, may receive a copy of the information received in this form.
6. If the requestor or receiver of the information is not a health care provider, the released information may not be protected by federal privacy regulations and may be re-disclosed.
7. I can request a copy of this release form.

**I have read the above statements and authorize to have this information disclosed as stated.**

_____ _____

Signature of Patient/Guardian/Patient Representative — Date

_____ _____

Print Name of Patient/Guardian/Patient Representative — Relationship to Patient

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

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