Authorization for Release of Information

Patient Name ____
Address (number and street) ________________________________
City, State, Zip Code _____________________________________
Telephone____________________ Date of Birth ______________________
Email address ____

I authorize Prospect OBGYN (Lifeline Medical Associates CC194) **to release my health information to:**
Name ____
Address ____
City, State, Zip ____
Telephone # _______________________________ Fax # ____________________

I authorize Prospect OBGYN (Lifeline Medical Associates CC194) **to obtain records from:**
Name ____
Address ____
City, State, Zip ____
Telephone # _______________________________ Fax # ____________________

This authorization applies to the following information:
___ Complete Medical Record
___ Other (Please list) ____

The purpose of the release is:
___ For treatment purposes
___ At the request of the patient
___ Other (please specify) ____

___ I authorize the above provider and members of its staff to furnish the information, including copies or faxed copies, as directed in this authorization. I further agree to release the provider and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance on it. I understand that this authorization will expire on ________________________, and if I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

____________________________________ ______________________________
Signature of Patient or legal Representative Date

____
If signed by Legally Authorized Representative, Relationship to Patient

NOTICE TO RECIPIENT OF INFORMATION

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, federal regulations may prohibit you from making further disclosure of this information unless further disclosure if expressed permitted by the written consent of the person to whom it pertains, or as otherwise permitted by federal regulations.

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