103 East 23rd Street, Panama City, FL 32405 | Phone: 850-769-0338 | Fax: 850-785-6088

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _________________________________, hereby authorize Emerald Coast OB/GYN to use and/or disclose the following protected health information:

Records requested from (Facility/Phone/Fax): ____

____

Records requested to be sent to (Facility/Phone/Fax): ____

____

For the purpose of (circle one): (1) Continuance of care (2) Insurance (3) Legal (4) Self

Information to be released:

( ) Office Notes
( ) Lab Results
( ) Radiology Results
( ) Pathology Results
( ) Obstetrical Records
( ) Operative Reports
( ) Cytology
( ) Entire Record
( ) Mammography Images on a disc and paper report
( ) Breast Imaging
( ) Other: ____________________

This authorization shall be valid for one year from the date signed, at which time this authorization to use or disclose protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the Facility address. I understand that a revocation is not effective to the extent that the facility has taken action in reliance on this authorization. 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 or state law. The Facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or State Law if it provides greater access rights).
- Refuse to sign this authorization.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital war, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem; HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

** PLEASE INITIAL BELOW FOR LABS**

PLEASE INITIAL _______ Yes _______ No — I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

PLEASE INITIAL _______ Yes _______ No — I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

____ Signature of Patient or Personal Representative

____________________ Date

______________________________ Patient's Date of Birth

____ Printed Name of Patient or Personal Representative

____ Patient's Social Security Number