Gynecology Specialists

A Division of Mid-Atlantic Women's Care, PLC

516 Innovation Drive, Suite 305 · Chesapeake, VA 23320
(757) 312-8221 · Fax (757) 312-8382

Rebecca M. Ryder, MD, FACOG
Linda M. Long, MD, FACOG
Zenette M. Leao, MD FACOG
Jeanne M. Busch, DO, FACOG
Kimberly A. Harris, RN, MSN, FNP

NOTE: Please mail records that are over 15 pages to the above address.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________________ **Date of Birth**: _______________________________
Phone: **H)** ________________________________ **Phone: C)** _________________________________
Address: _________________________________ **City/State/Zip**: _____________________________
Please Note: Copy Fee May Be Charged For Medical Record

I authorize the following healthcare facility to disclose protected health information as described below:
Facility Name: _____________________________ **Facility Phone**: _____________________________
Facility Address: ____________________________ **Facility Fax**: ______________________________
City, State, Zip: ____________________________

Date and Type of Information to Disclose:
□ All information 2 years prior to date last seen
□ All information from dates : ____________________
□ Specific information and dates requested: _________________
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The purpose of disclosure is:
□ Request of the individual signing below
□ Continuation of Care (e.g., VA Med Ctr)
□ Referral or other __________________
□ Change of Insurance or Physician

RESTRICTIONS: I understand that only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and/or other communicable diseases. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:
Release to: ____
Address: ____
City, State, Zip: ____ □ Please mail records
Fax: ______________________ Phone: ____________________________ □ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Practice's Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to any insurance company where the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my refusal will not affect my ability to obtain treatment. I understand that any disclosure of information carries with it the potential for redisclosure and the information then may not be protected by confidentiality laws. I further understand that I may request a copy of this signed authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. If I have questions about disclosure of my health information, I can contact the Practice's Privacy Officer.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. All of my questions have been answered, and I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records.

X ____ ______________________________________
Signature of Patient/Parent/Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status) — Date

____ ____
Printed Name of Authorized Representative — Relationship/Capacity to Patient or description of authority to act for patient

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Address and telephone number of authorized representative