



CENTRAL CAROLINA OB/GYN
A DIVISION OF PIEDMONT HEALTHCARE FOR WOMEN

Medical Information Release Form (HIPPA release form)

**** Authorization for Use or Disclosure of Protected Health Information****

Name: _____ **Date of Birth:** ____/____/____

I authorize the release of information including the diagnosis, records: examination rendered to me, and claims information. This information may be released to.

- Spouse _____
- Child(ren) _____
- Other _____

*****Effective Period*****

This authorization for the release of information covers the period of healthcare from:

a. _____ to _____

*****OR*****

b. All past, present, and future periods.

*****Extent of Authorization*****

- a. I authorize the release of my complete health record (including records relating to pap smears, mental healthcare, communicable diseases HIV, Aids, HSV, and treatment.
- b. Partial Health
- c. Full Financial Copay & Balance or Collection amounts
- d. Partial Financial Copay only
- e. Full Test Results
- f. Partial Test results

*****OR*****

- g. I authorize the release of my complete health record with the exception of the following information.
 - Communicable diseases (including HIV, AIDS and HSV)
 - Mental health records
 - Pap Smear
 - Other Please Specify _____



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This Release of Information will remain in effect until terminated by me in writing. If any information changes, I am responsible for contacting the office to update all changes.

Messages

Please call Home Work Cell Phone: _____

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- _____

The Best time to reach me is (Day) _____ Between (Time) _____

I understand that I have the right to revoke this authorization in writing at any time. A revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I do not authorize anyone to have authorization to my medical information.

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____