TRANSFER OF RECORDS FROM WEST END OB\GYN. PC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Social Security# ____________________

____
Name

____
Date of Birth Maiden Name

____
Address

____
City, State, Zip

HEALTHCARE PROVIDER RELEASING PHI

West End OB/GYN

7601 Forest Avenue, Suite 100

Richmond, Va. 23229

(804) 282-9479 Fax (804) 285-9805

HEALTHCARE PROVIDER RECEIVING

____
Name

____
Address

____
City, State, Zip

____
Phone

PHI TO BE RELEASED

___ All records or ____

___ All dates or ____

REASON FOR DISCLOSURE

___ Further Medical Care ___ Legal Inquiry ____ Insurance ___ Changing Physicians

____ Personal ___ Other ____

This authorization is good until the following date_________________________, or for 90 days from the signed date.

I understand that if my PHI is disclosed to someone who is not required to comply with federal privacy regulations, then such information may be re-disclosed and would no longer by protected.

I understand that I have a right to revoke this authorization at any time. My revocation must be submitted in writing. I am aware that my revocation is only effective to the extent that action has not already been taken as a result of my signing this form.

I understand that I do not have to sign this authorization and that my refusal will not affect my ability to obtain treatment from West End OB/GYN Associates, nor will it affect my eligibility for benefits. I understand that I have a right to inspect or copy the health information to be disclosed, and I may arrange for such inspection or copying by contacting West End OB/GYN Associates. I also have a right to a copy of this signed authorization.

____
Patient Signature

____
Date

_____________________________Witness