VALLEY OBSTETRICS & GYNECOLOGY

HIPAA Medical Release of Information

I, _____ date of birth _____
authorize and give my consent for Valley Obstetrics and Gynecology to transfer my record in the following arrangement.

My records are ***currently*** at the following physician's office/location:

Name of Doctor/Clinic/Other: _____
Address: _____
_____

Phone: _____ Fax: _____

I would like my records ***sent*** to the following physician's office/location:

Name of Doctor/Clinic/Other: _____
Address: _____
_____

Phone: _____ Fax: _____

Specific information to be disclosed (if blank, the COMPLETE record may be disclosed):

_____

This authorization will expire in:
- ○ 1 month
- ○ 1 year
- ○ When revoked in writing

I understand and acknowledge the following:

1. I do not have to sign this authorization in order to get health care benefits.
2. I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by federal privacy regulation.
3. I may revoke this authorization at anytime. My revocation must be in writing and submitted to Valley Obstetrics and Gynecology, attn: Privacy Officer. If I do revoke this authorization my revocation will not affect any actions already taken by Valley Obstetrics and Gynecology based upon this authorization.
4. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws my no longer protect it.
5. If I have any questions about this authorization, I may contact Provo Valley OB-GYN at 801.374.1801, or American Fork Valley OB-GYN at 801.756.9635.

I certify that I have read and understand this authorization.

Signature _____ Date _____
Patient or Patient's Representative

Printed Name _____ Relationship _____
If other than patient

* This request will take approx. 1-3 business days to process. *