

Authorization for Disclosure of Health Information

1. I hereby authorize Carteret Ob-Gyn Associates to disclose the following information from the health records of:

Patient Name _____ Date of Birth _____
Address _____ Telephone _____
_____ Patient Number _____

covering the period(s) of healthcare:

From (date) _____ to (date) _____
From (date) _____ to (date) _____

2. Information to be disclosed:

Complete health record(s) (all medical information)

Or disclose only the following:

- | | |
|--|---|
| <input type="checkbox"/> History & physical examination | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Laboratory tests |
| <input type="checkbox"/> Photographs, videotapes, digital or other images | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> Discharge summary | |
| <input type="checkbox"/> Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection. | |
| <input type="checkbox"/> Behavioral health service/psychiatric care | |
| <input type="checkbox"/> Treatment for alcohol and/or drug abuse | |
| <input type="checkbox"/> Other (please specify) _____ | |

3. This information is to be disclosed to _____

Address _____

_____ Fax _____

for the purpose of _____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following day, event or condition:

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____
(Patient's signature) (date)

Or (legal representative) (relationship to patient) (date)

(Signature of witness and title) (date)

Translated by _____
Patient acknowledges understanding _____