



# Wendover OB-GYN & Infertility, Inc.

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[www.wendoverobgyn.com](http://www.wendoverobgyn.com)

## Authorization to Disclose Protected Health or Billing Information Request

I give Permission to release the health information of:

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

### Release Information:

From	To
Name _____	Name _____
Address _____	Address _____
Phone # _____	Phone # _____
Fax # _____	Fax # _____

### Purpose of Release (check reason):

- Request of individual/personal       Insurance       Disability  
 Transfer       Legal       Continuation of Care       Other: \_\_\_\_\_

### Please Send (check appropriate box):

- All Records (including visits/imaging/labs)       Specific Date(s) of Service \_\_\_\_\_ to \_\_\_\_\_  
 Office Notes \_\_\_\_\_       Specific Imaging \_\_\_\_\_  
 Specific Labs \_\_\_\_\_       Other \_\_\_\_\_

I understand that I am authorizing the release of all medical information from my medical record unless specifically restricted as indicated below (you must initial if you want any restrictions, no check marks):

\_\_\_\_\_ HIV/AIDS or related testing      \_\_\_\_\_ Mental Health      \_\_\_\_\_ Chemical Dependency (drug/alcohol)

This authorization is valid for 180 days from the date signed or until \_\_\_\_\_ whichever is shorter. This authorization may be revoked at any time by notifying Wendover OB-GYN in writing, except when this authorization was obtained as a condition of acquiring life insurance coverage. Information used/disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship of Representative to Patient

\_\_\_\_\_  
Relationship to Patient, if not the Patient