Wendover OB-GYN & Infertility, Inc.

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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