



Goldsboro Ob-Gyn Associates, P.L.L.C.

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PATIENT AUTHORIZATION FOR MEDICAL INFORMATION

PATIENT NAME: _____

DOB: ___/___/___ LAST FIRST MI MAIDEN/OTHER
SS#: _____ CHART#: _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION

FROM:	Name: _____
	Address: _____
	City, State, Zip: _____
TO:	Name: _____
	Address: _____
	City, State, Zip: _____

- Send all of my Medical Records
- Send only my records from (date) ___/___/___ to (date) ___/___/___
- Any other personally identifiable information used by Goldsboro OB-GYN, Associates to make medical decisions about me. Please describe: _____
- Send all of my Billing Records

I specifically authorize the release of information relating to :

- Substance abuse (including alcohol/drug abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)
- X

Signature of Patient or Legal Guardian

Date

I wish to have the requested information sent in the following format:

- Photocopies/Mail
- Electronic transmission (FAX Number: _____)

The Purpose of releasing this data shall be:

- Continued Medical Treatment
 - Complete transfer of Care
 - Other: _____
 - Personal
 - Second Opinion
- Reason for Transfer: _____

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will automatically expire after 90 days from the date on which it is signed.

Signature of individual or guardian or Personal Representative of patient's estate

Date Signed

Witness

Date