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

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PATIENT AUTHORIZATION FOR MEDICAL INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN/OTHER

DOB: ___/___/_____ 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 all of my Billing 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: _____.**

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
- ☐ Personal
- ☐ Second Opinion
- ☐ Complete transfer of Care Reason for Transfer: _____
- ☐ Other: _____

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