Lake Champlain OB/GYN PC

206 Cornelia Street, Suite 306, Plattsburgh, NY 12901
Phone (518) 566-9452 Fax (518) 562-7189

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

We will not fax medical records unless it is an emergent situation.

Patient's Name (please print) ______________________ **Date of Birth** __________

Address ____

Phone (____)______________________ **SS#** ______________________

I authorize Dr. ______________ **of Lake Champlain OB/GYN, PC to take the following action:**

[ ] **Release Information to:** ***OR*** [ ] **Obtain information from:**

Dr. ______________________________ Office Phone ______________

Address: ____

Street *City* *State* *Zip Code*

❖ **Purpose and Need for Release**

❑ Treatment ❑ Legal Services ❑ Insurance Coverage ❑ Personal ❑ Other ______________

❖ **This information may be released by:** ❑ Copy ❑ Fax(Urgent/Emergent situations only) ❑ Verbal

❖ **I authorize the release of the following Protected Health Information (PHI) and/or medical records, if such information exists:**

❑ All Information (The request to send all medical information will include the release of HIV/AIDS and/or sexually transmitted disease-related and/or psychological or psychiatric treatment and/or drug/alcohol abuse treatment information. **I understand that this serves as a dual release inclusive of sensitive medical information, including HIV unless otherwise requested.**

❑ All Information with the following exceptions (Please specify) ______________________

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OR (Select desired information to be released)

❑ Annual Exam Notes ❑ GYN Exam Notes / Assessments ❑ Prenatal Records

❑ Diagnostic / Lab test results ❑ Operative Report ❑ Discharge Summary

❑ Other ____

❖ **This Authorization covers treatment Period(s)** (Please select"All" or specific treatment dates)

❑ All episodes of care OR ❑ From __________ to __________

❑ From __________ to __________

❖ **This Authorization expires (Date or Event)** ____________________

Note: If no date is noted, this authorization will expire **one year** from the date it was signed.

❖ **I understand that**

- ❖ My right to healthcare treatment is not conditioned by this authorization.
- ❖ I may cancel (revoke) this authorization at any time by submitting a request to our office. I understand that the cancellation will not apply to information already released in response to this authorization.
- ❖ If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations, this information could be re-disclosed.

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❑ **I *am not*** transferring my care to this physician/facility on a permanent basis.

❑ **I am** leaving Lake Champlain OB/GYN, PC and transferring my care to this physician/facility permanently.

In order to better serve our patients, your feedback is appreciated.

Reason for transferring from practice:

❑ Moving ❑ Insurance ❑ Dissatisfied ❑ Other, please specify: ____________________

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Signature of patient or legal patient representative ____________________

Date ____________________

If the above signed is a legal patient representative:

Print Name ____________________ **Phone Number** ____________________

Relationship to Patient ____________________

Witness (Optional) ____________________ **Date** ____________________

LCOG Use Only

Date Information was forwarded ____________________

LCOG Staff member who addressed request to release information ____________________