



Essex County OBGYN Authorization to Use and Disclose Protected Health Information

Records
Coming
From:

Physician: _____
 Practice: _____
 Address: _____
 City, Zip: _____

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____
 Any other Previous Names: _____
 Patient Address: _____ Phone # _____
 City: _____ State _____ Zip: _____ EMAIL _____

I hereby authorize Essex County OBGYN to send Records to:

Name/Facility: _____ Attention: _____
 Address: _____ Phone #: _____
 City: _____ State _____ Zip: _____ Fax #: _____
 Purpose of Request (optional) Personal Referral or 2nd Opinion Legal Insurance Other _____
 Transfer from Practice/Reason? _____

Specific Records/Report(s) to be released:

Please provide a 2 year abstract of my records.
 An abstract contains; 2 years of office visits and labs, 5 years of diagnostic tests

Complete Record
 This will include ALL records

Other-please be specific, include dates and MD's under comments.

*** Please do not pre-pay. You will be invoiced for your selection by our vendor ***
 Comments

COPY FEE: For Patient record requests - Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record or more than the two year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the applicable US state statute governing fees for medical records will be applied.

Restricted Authorization to Release Protected Information:

STOP

IMPORTANT - It is extremely important that you select either you "DO" or "DO NOT" for each item contained in this section. Please do not skip any items as it could impact our ability to fulfill your request and cause delays.

Release Records? Check one

I DO DO NOT want Mental/Behavior Health or Disability Services Provider Documentation * released.

I DO DO NOT want HIV/AIDS Screening Test Results released

I DO DO NOT want information about Alcohol and/or Substance Abuse Treatment *** released

I DO DO NOT want Genetic Testing/Test Results ** released

I DO DO NOT want Confidential Communications with a Social Worker released

I DO DO NOT want information about Rape/Sexual Assault Victim Counseling released

I DO DO NOT want Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability released

I DO DO NOT want information about Sexually Transmitted Disease (STD) released

I DO DO NOT want information about Domestic Violence Victim Counseling released

* This Authorization is not valid for use or disclosure of psychotherapy notes.
 ** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.
 *** Only applicable to records that are created by an individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here

Date Here

Signature of Patient	Date
Parent/Legally Recognized Representative Signature**	Relationship/authority to act for patient
	Date

Term: This Authorization will remain in effect until Essex County OBGYN Associates Inc fulfills this request.
Revocation: I understand that I may revoke this Authorization at any time by requesting it of Essex County OBGYN Associates Inc in writing at the address listed below. The revocation will be effective immediately upon Essex County OBGYN Associates Inc receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Essex County OBGYN Associates Inc in reliance on this Authorization before it received my written notice of revocation.
Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Essex County OBGYN Associates Inc.
Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Essex County OBGYN Associates Inc.
Access: I understand that in certain circumstances Essex County OBGYN Associates Inc. has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.