GYNECOLOGY & OBSTETRICS ASSOCIATES OF TALLAHASSEE
CARING FOR GENERATIONS OF WOMEN

Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name _____

Patient's Address: _____ City _____ State _____ Zip_____

Date of Birth _____ Social Security # _____ Phone Number _____

I authorize my physician and/or administrative and clinical staff at Gynecology and Obstetrics Associates of Tallahassee or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Release Information:		**Person or Entity to Receive Information:**	
Name/Organization:	Gynecology and Obstetrics Associates of Tallahassee	Name/Organization:	
Address:	1405 Centerville Road, Ste 4200	Address:	
City, State, Zip:	Tallahassee, FL 32308	City, State, Zip:	
Phone #:	850-848-4628	Phone #:	
Fax #:	850-702-9727	Fax #:	

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

__ Complete Medical Record __ Billing Records __ Office Notes __ Ultrasound Reports
__ Lab Reports __ Surgery Records __ Mammogram Reports
__ Obstetrical (OB) Records __ Pap Smear / Biopsy Reports __ Other (specify): _____

DATES OF SERVICE: _____
PURPOSE: ___ Changing Physicians ___ Personal Copy to Patient ___ Attorney ___ Insurance ___ Workers' Compensation

Other _____

This authorization will expire on: _____ (If no date is specified, it will expire 365 days after date signed).

CHECK AND INITIAL BELOW:

___I DO ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.
Initials of individual giving authorization: _____

___I DO ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**.
Initials of individual giving authorization: _____

___I DO ___I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment.
Initials of individual giving authorization._____

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I have read and understand the nature of this authorization and I have been provided a copy of Gynecology and Obstetrics Associates of Tallahassee's (GOAT) Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at Gynecology and Obstetrics Associates of Tallahassee, 1405 Centerville Road Ste 4200, Tallahassee, Florida 32308, Attn: Compliance Officer. I understand that a revocation is not effective to the extent that my physician or Gynecology and Obstetrics Associates of Tallahassee has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect GOAT's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) healthcare services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient Date
(If applicable, attach document of guardianship or Power of Attorney)