Medical Information Release Form for
Gynecologic Surgeons & Obstetricians, P.C.

HIPAA RELEASE FORM

AUTHORIZATION WHEN PATIENT REQUESTS DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ I hereby authorize Gynecologic Surgeons & Obstetricians, P.C. to disclose any or all medical information concerning my injuries, disabilities, and physical condition, including all medical records and radiographs, pictures, or other information including any condition or care related to any drug and/or alcohol dependency, psychological diagnosis, or HIV or AIDS status to:

☐ Spouse____

☐ Significant Other ____

☐ Parent(s) ____

☐ Child(ren) ____

☐ Other _______________________________________Relation:________________

☐ My personal health information is NOT to be released or disclosed to anyone.

This authorization expires upon written notice from me. I understand I have a right to revoke this authorization in writing except to the extent Gynecologic Surgeons & Obstetricians, P.C. has taken action or has relied upon authorization. The authorization may be revoked in writing delivered to Gynecologic Surgeons & Obstetricians, P.C.

The information used or disclosed under this authorization may be subjected to redisclosure by the recipient and no longer protected by federal privacy laws.

____________	______________________________________	_______________
Date Signed	Patient Signature	Date of Birth
____________	______________________________________	_______________
Date Signed	Signature of Personal Representative of Patient	Relationship