grace
OB/GYN PHYSICIANS

Authorization for Release of Medical Records

(NCCOM-015.00.a01)

2 Yorkshire Street
Asheville, NC 28803
Phone 828.252.1050
Fax 833.450.0738

Patient Name: _____ **DOB:** _____ **Last 4 of SSN:**_____
Patient Address: _____
Primary Phone: _____ **Secondary Phone:** _____

I hereby authorize records obtained in the course of my evaluation/treatment to be (**CHECK ONE**): ☐ sent to ☐ received from

Name of Person/Facility: _____
Address: _____
Phone Number: _____ Fax Number: _____

RECORDS TO BE SENT BY: ☐ Fax to provider ☐ Mail to patient ☐ Patient will pick up

RECORDS TO BE RELEASED

☐ Past 3 Years (standard release)
☐ My Complete Medical Record —> Please specify the reason for entire medical record to be disclosed.
Transfer of Care _____ PCP Records _____ Other_____
☐ Medical Data Related to: _____ ☐ Other: _____

Disclosure will include: (check all that apply)

☐ History & Physical ☐ Progress/Physician Notes ☐ Operative Reports ☐ Radiology Reports
☐ Lab Reports ☐ Pathology Reports ☐ Other: _____

PLEASE INITIAL ON EACH LINE BELOW TO INCLUDE THESE SPECIFIC RECORDS IN THIS RELEASE.

NOTE: Failure to initial the items below indicates that you do not authorize the release of those specific records.

_____ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse
_____ Records related to HIV/AIDS testing, results, diagnosis, or treatment
_____ Records related to genetic testing and results
_____ Psychiatric and/or psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including any narrative summaries, tests, social work assessment, medications, psychiatric examination, progress notes, consultations, and/or treatment plans

THIS AUTHORIZATION SHALL REMAIN ON FILE AND VALID FOR ONE (1) YEAR FROM THE DATE SIGNED. AFTER ONE (1) YEAR, THIS AUTHORIZATION SHALL EXPIRE AND A NEW AUTHORIZATION WILL BE REQUIRED TO DISCLOSE MY HEALTH INFORMATION. I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. I UNDERSTAND THAT I HAVE THE RIGHT TO LIMIT THE TYPE OF INFORMATION RELEASED. GRACE OBGYN WILL ACT ON THIS REQUEST WITHIN THIRTY (30) DAYS OF RECEIPT OR WITHIN SIXTY (60) DAYS IF THE REQUESTED INFORMATION IS NOT MAINTAINED OR ACCESSIBLE TO GRACE OBGYN ON SITE. GRACE OBGYN CANNOT GUARANTEE THAT THE RECIPIENT WILL NOT REDISCLOSE MY HEALTH INFORMATION TO A THIRD PARTY THAT IS NOT SUBJECT TO APPLICABLE FEDERAL AND STATE LAW GOVERNING THE USE AND DISCLOSURE OF MY HEALTH INFORMATION. GRACE OBGYN MAY IMPOSE A FEE TO COVER THE COST OF LABOR, COPYING, POSTAGE, AND PREPARING A SUMMARY OF THE REQUESTED INFORMATION. I UNDERSTAND THAT SIGNING THIS AUTHORIZATION IS VOLUNTARY AND WILL NOT CONDITION MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS.

_____ _____ _____
Signature of Patient or Substitute Decision Maker | Date | Witness Signature

_____ _____
Relationship to Patient (if Substitute Decision Maker) | Reason for Signing Instead of Patient

ACKNOWLEDGEMENT OF RECORDS RECEIVED IN OFFICE

_____ _____ _____ _____
Signature | Relationship to Patient | Date | Office Staff Signature

Patients can email this form directly to tasha.rushing@unifiedhc.com