

AUTHORIZATION for Disclosure of Protected Health information

My ObGyn Affiliates

1600 Specht Point Rd, Suite 127, Fort Collins, CO 80525
Phone (970) 591-9559 Fax (833) 471-5469

Dr Catherine Coffman MD
Dr Karen Hayes DO
Dr Kevin Tool MD
Alyssa Starkson CNM

Patient Information: Last Name: _____ Previous Last Name: _____
First Name: _____ Middle: _____ Date of Birth: / / Last 4 SSN: _____
Phone: () - _____ Email: _____
Street Address: _____ City: _____ State: _____ Zip: _____

Purpose of Request: Transfer Care to My ObGyn Continuity of Care Personal Use Legal/Insurance
 Other: _____

Records Provided by:

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Records to be received by:



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Information or Specific Records Requested:

- Last Two years of Medical History Entire Medical Record (Includes all records below)
- Office Notes/Progress Notes (Dates: _____ To _____)
 Obstetric Care Records (Prenatal, Labs, Ultrasound Reports, Deliveries)
 Gynecological Records (Including but not limited to: last PAP / cervical screening)
 Pathology Reports (Dates: _____ To _____)
 Laboratory Results (Dates: _____ To _____)
 Radiology /Imaging Reports Please do not send large image files on discs (Mammograms, Ultrasounds, MRI)
 Hospital Encounters (Including, but not limited to: Operative Reports, Pathology, Discharge Summaries)
 Immunization Records
 Prescription/pharmaceutical records (Including, but not limited to: NDC numbers and drug information)
 Fertility Treatment (Including, but not limited to: IVF, Surrogacy)
 Billing/ Financial Records (Including, but not limited to: Billing statements, invoices, itemized bills)
 Insurance Information (Including, but not limited to: subscriber information, insurance cards)
 Other: _____
Unspecified dates: Month _____ Year _____

Authorize to Release Sensitive Information I understand that my health records may contain sensitive information within notes, records, reports, billing, statements, financial records, and all other documents which are a part of the release of this information. I hereby authorize the release and re-disclosure of all information, to the Requestor, its consultants, experts, agents and/or other counsel relating to:

(Please acknowledge each)

- HIV/AIDS testing or treatment
 Behavioral or Mental Health services
 Substance abuse or treatment of Drugs/Alcohol
 Genetic testing/counseling

THIS FORM DOES NOT AUTHORIZE RE-DISCLOSURE OF MEDIAL INFORMATION BEYOND THE LIMITS OF THE CONSENT. Where alcohol/drug abuse information has been disclosed through records that are protected by federal law, or mental health records protected by state law, further disclosure is prohibited without specific written consent of the individual or as otherwise permitted by such law and/or regulations. A general authorization is not sufficient for these purposes.

I understand that this authorization is voluntary and I may revoke it in writing at any time. I understand that revoked authorizations do not apply to information already released. This authorization expires 90 days from the date of signature unless otherwise specified. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations (HIPAA).

Signature of Patient/Legal Representative: _____ Date: _____
Relationship to Patient (if applicable): _____