

# My ObGyn

A division of OB/GYN Affiliates

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

**\*PLEASE MAIL RECORDS OVER 25 PAGES - PLEASE DO NOT FAX\***

## Authorization to Release Health Information

Physician or facility to provide records: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ SS# last 4 digits \_\_\_\_\_

Person to receive records: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Fax: \_\_\_\_\_

### Health Information to be Released:

I am permanently transferring my care to another Physician? Yes No

My entire medical record, or

My health information related to the following treatment or health condition: \_\_\_\_\_

My health information related to drug/alcohol abuse

My health information related to HIV/ AIDS

My health information related to psychological / psychiatric conditions, including  
Psychotherapy notes

My health information for the dates of: \_\_\_\_\_

This authorization is made for the following purpose:

At my request;

Other: \_\_\_\_\_

### Conditions of Authorization

1. This authorization will expire on (date or event): \_\_\_\_\_

2. I may revoke this authorization at any time by notifying my health care provider in writing, and it will be effective on the date notified to the extent that my health care provider has already acted upon this authorization.

3. Once my health care provider discloses this health information, the person or organization that receives it may re-disclose it. Federal privacy laws may not longer protect it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_