OB-GYN ASSOCIATES OF ITHACA
20 Arrowwood Dr.
Ithaca, N.Y. 14850
Phone: 607-266-7800 Fax: 607-216-0093

AUTHORIZATION FOR DISCLOSING OR OBTAINING PROTECTED HEALTH INFORMATION (PHI)

Patient's Name (please print)_____ Date of Birth_____

Address:_____

Phone #:_____ Work/Cell #:_____

I hereby authorize OB-GYN ASSOCIATES OF ITHACA to take the following action:

☐ OBTAIN RECORDS FROM: **OR** ☐ RELEASE RECORDS TO:

Provider/Facility:_____

Address:_____

Fax number:_____ Phone:_____

Reason for release of records:

☐ Continuing Care ☐ Legal matters ☐ Personal Use ☐ Second opinion

Information to be released: (Most physicians only require the last 5 years of records)

☐ Annual/progress notes ☐ Pregnancy records ☐ Labs ☐ X-rays ☐ Surgery

Other:_____

This information may be released by one of the following modes:

☐ Fax ☐ Copy

I understand this authorization will expire 1 year after date of signature. I further understand that I may revoke this authorization at any time by written notification, (with the exception of actions already taken in reference to such release). I understand my treatment, payment, enrollment or eligibility for benefits (as applicable) will not be contingent on completion of this form. I understand that this information may be subject to re-disclosure and therefore no longer protected by State or Federal privacy regulations.

I understand these records may include the following sensitive medical information and I authorize the disclosure of the following protected health information by initialing below:

HIV/AIDS_____ **Drug or alcohol abuse treatment_____**

Signature:_____ **Date:_____**