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## REPLY Ob/Gyn & Fertility

Phone: 919-230-2100 | Email: info@replyobgyn.com | Fax: 919-230-2133  
7535 Carpenter Fire Station Road, Suite 105 | Cary, NC 27519

### Authorization for Release of Medical Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Patient's Phone Number: \_\_\_\_\_ Date of Request: \_\_\_\_\_ Date Needed: \_\_\_\_\_

I voluntarily authorize Reply OB/GYN & Fertility, PLLC to **RELEASE** information to:

Name of Provider or Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # / Fax #: \_\_\_\_\_

I voluntarily authorize Reply OB/GYN & Fertility, PLLC to **OBTAIN** information from:

Name of Provider or Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # / Fax #: \_\_\_\_\_

Purpose of this Request: **(Circle one)**

Healthcare    Insurance Coverage    Personal    Transfer of Care    Other: \_\_\_\_\_

Type of Records Requested: **(Circle)**

History & Physical    Pap Smear    Procedure Report    Lab Results    Imaging    Physical Therapy

Other \_\_\_\_\_ Specific Dates: \_\_\_\_\_

Authorization Valid for: **(Circle one or indicate date)**    One year

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- I may revoke this authorization at any time by submitting a written request to Reply OB/GYN & Fertility, PLLC, except where a disclosure has already been made in reliance on my prior authorization
- I understand that the medical information may be disclosed pursuant to this authorization for medical treatment consultation, billing, or claims payment, or other purposes as I may direct.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed and may no longer be protected under federal or state law
- I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization
- There may be a charge for the requested records.

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if requester is not the patient): \_\_\_\_\_