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 - OUTGOING

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 #: _____

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): _____