Oakdale OB/GYN, P.A.

PATIENT AUTHORIZATION AND REQUEST FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_______________________________ Date of Birth:_________________________

Patient Address:____
Street Apartment Number

____Phone Number:_________________________
City State Zip

By signing this authorization, I request Oakdale Obstetrics and Gynecology, P.A. (Oakdale), to use and/or disclose certain past and present protected health information (PHI) about me to:

Name of clinic, hospital or company to receive this information and phone number.
____( ) _________________.

Address: ____

Specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released):
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____

Reason for record release:____

I hereby authorize Oakdale Obstetrics and Gynecology, P.A. to release information including diagnosis and records of treatment concerning past medical history and current care. Please circle any items you do not want released:
mental health psychiatric disorders chemical dependency HIV/AIDS virus STDs
Pregnancy research study information

Oakdale **will** assess a charge for copying and postage costs in association with using or disclosing the PHI.

This authorization will expire on ______________________________.
{Expiration Date or Defined Event}

I do not have to sign this authorization in order to receive treatment from Oakdale Obstetrics and Gynecology, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 8559 Edinbrook Parkway, Suite 106, Brooklyn Park, MN 55443.

Signed by:_________________________________ _________________________________
Signature of Patient or Legal Guardian Relationship to Patient (If signed by Guardian)

_________________________________ _________________________________
Patient's Previous Last Name Print Legal Guardian Name, if Applicable

____
Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION