



**OB-GYN &
MIDWIFERY**
ASSOCIATES OF ITHACA

OB-GYN & MIDWIFERY 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 & MIDWIFERY 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: _____