Gulfport Obstetrical & Gynecological Clinic, P.A.

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Authorization for Release of Protected Health Information

Gulfport OBGYN is able to accept records via paper, disk (CD), or electronic format. Please email records to the HIPAA Compliant Email: medicalrecords@gulfportobgyn.com

To: _____ From: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor — Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____ _____
Street Address — Street Address

_____ _____
City, State and Zip Code — City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ SS#:_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with patient care. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All PHI in the record

Healthcare information related to the following condition, treatment or date: _____

☐ Progress Notes ☐ Laboratory Tests ☐ X-Ray Test / Reports
☐ History and Physical Examination ☐ Discharge Summary ☐ Consultation Reports ☐ Operative Reports
☐ Itemized Billing Statement ☐ Pathology Results ☐ Other: _____

☐ YES ☐ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I Understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ YES ☐ NO I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

I UNDERSTAND THE FOLLOWING:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility or benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that information provided in PDF format, sent via encrypted e-mail or disk, is no longer protected by Gulfport OBGYN once it leaves the facility.
6. I have the right to receive a copy of this form after I sign it.
7. The process to transfer records may take up to 30 days.

Patient Signature: _____ Date Signed: _____

Signature of Personal Representative: _____ Relationship: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED