Memphis Obstetrics & Gynecological Association, P.C. (MOGA)

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(662) 349-5554
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections MUST be completed)

Patient:_____ Birth Date: _____

Address:_____ Phone: ( ) _____

_____ SS#: _____

Release From: _____ **Release To**: _____

_____ _____

_____ _____

Specific type of information to be released: [ ] any/all records [ ] Diagnostic reports [ ] Lab results
[ ] Chart notes [ ] Consultation notes [ ] Operative notes [ ] Other_____
for date range: _____to:_____
(If no time period specified, record from previous 5 years only will be released)

Purpose of disclosure: [ ] Transfer of Care – Reason:_____
[ ] Disability [ ] Worker's Comp [ ] Social Security [ ] Insurance [ ] Attorney Request
[ ] Other:_____

There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages.

I understand that my medical records may contain information **related to communicable diseases and infection information** as defined by statute and **Department of Public Health Rules** (which include venereal disease "VD," tuberculosis "TB," Hepatitis (any form), Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS" and AIDS Related Complex "ARC;" **alcohol and/or drug abuse treatment information** protected under regulations in 42 Code of Federal Regulations, Part 2; and **mental health treatment records, psychological services** and/or **Social Services** information including communications made to or by a social worker, psychologist or psychiatrist.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I may contact the Privacy Office at the disclosure location.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient