GREENSBORO
OB-GYN ASSOCIATES
a division of Piedmont Healthcare for Women, P.A.
personalized care for every woman

AUTHORIZATION FOR RELEASE

510 North Elam Avenue, Suite 101 • Greensboro, NC. 27403
P (336) 854-8800 • F (336) 299-4308 • www.gsoobgyn.com

Fee for release of records to patient: $15.00

PATIENT INFORMATION:

Name: _____ **Date of Birth:** _____

Address: _____
Street Apt #/ Suite

_____
City State Zip County

Phone Number: _____

I do hereby authorize: *Greensboro OB/GYN Associates* **Phone Number:** *(336) 854-8800*

Facility Address: *510 Elam Avenue, Suite 101, Greensboro, NC 27403*

To Release:

- ☐ Entire Record
- ☐ Pap Smear
- ☐ Mammogram
- ☐ Office Notes
- ☐ Lab Reports (specify, if needed)
- ☐ Pathology
- ☐ Bone Density
- ☐ Hospital Records
- ☐ Specific Date(s): _____
- ☐ Other: _____

☐ I do
☐ I do not

Authorize release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, sexually transmitted disease(s), psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.

Send Records to: _____
Name of Facility

_____
Street Apt #/ Suite

_____
City State Zip County

Purpose of Disclosure:

- ☐ Referral to specialist
- ☐ Disability
- ☐ PCP/Internist
- ☐ Other: _____
- ☐ Insurance
- ☐ Personal
- ☐ Worker's Compensation
- ☐ Legal Issue
- ☐ Change of Provider

I do hereby authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with a written notification, but it will not affect any information released prior to cancellation. I understand that the information used or disclosure may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

_____ _____
Signature Date

_____ _____
Witness Signature (office use) Date