OAKBEND MEDICAL GROUP

This completed form authorizes a third party to disclose a patient's protected health information to OakBend Medical Group.

Authorization for Disclosure of Protected Health Information

Patient Contact Information

Name of Patient _____ Date of Birth _____

Address (City,State,Zip) _____ Phone _____

Dates of Service _____

Reports to be Disclosed

Please indicate those reports that you would like to be disclosed.

History and Physical Exam	_____	Growth Chart	_____
Consultation Reports	_____	Operative Reports	_____
Progress Notes	_____	Billing Claim Forms	_____
Radiology Reports	_____	Itemized Statement of Charges	_____
Laboratory Reports	_____	All Information	_____
Pathology Reports	_____	Other	_____
Immunization Records	_____		

Records Released From

Name _____ Phone _____

Mailing Address _____ Fax _____

City, State, ZIP _____

Records Released To

Name _____ Phone _____

Mailing Address _____ Fax _____

City, State, ZIP _____

Reason for record release _____

Authorization

I authorize the third party named in the above section to disclose the protected health information about myself (or the patient) as described above.

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
  Expiration
- I may revoke this authorization at any time by notifying OBMG in writing. If I revoke the authorization, I understand that it will have no affect on actions OBMG took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- OBMG may not condition treatment or payment on my completion of this form.
- OBMG reserves the right to verify my identity or guardianship.

Signature _____ Date _____

Printed Name _____

Relationship to Patient _____

Thank you for choosing OakBend Medical Group