Authorization for Disclosure of Health Information

phone: 919-781-9555 **fax: 919-781-1070** arbor-obgyn.com

I, the undersigned, authorize Unified Women's Health, P.A., 2615 Lake Drive, Suite 201, Raleigh, NC 27607 (d.b.a ARBOR OBGYN) to release my health information as noted below. Please fax or mail the completed authorization form to Arbor ObGyn.

***** All sections must be legible & completed in order for request to be processed *****

Patient Information:

Patient Full Name: _____ Other Names during Treatment: _____

Patient Address: _____

City: _____State: _____ Zip: _____ Phone #: _____

Email Address: _____ Date of Birth: _____

Release Information To (faxed, unless otherwise requested):

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: □ Transfer of Clinical Care (I am not continuing as a patient of Arbor ObGyn) □ Personal Records □ Attorney
□ Referral by Arbor ObGyn to another practice □ Primary Care Provider needs records □ Second Opinion
□ Other Reason**:** _____

Information To Be Released:

Specify Dates of Records to be released: _____ to _____

□ ENTIRE RECORD □ Current Prenatal Records □ Labs □ Imaging □ Surgery Notes □ Office Visits
□ Specific information: _____

**North Carolina Statute §90-411: A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs. Charges outlined above will be applied for all copies released directly to the patient or sent on patient's behalf. Your account will be billed, and payment must be made prior to release of records. I understand that medical record processing may be outsourced to a professional Health Information Handler (HIH), and that I will receive an invoice for records per North Carolina Statutes, and payment is made directly to the HIH.

Authorization to Release Protected Health Information

****Required-** Please indicate how particularly sensitive protected information should be handled.
Selecting ENTIRE RECORD above means EVERYTHING will be included.

If you specifically DO NOT want the following sensitive information disclosed, check the applicable box(es) below:

□ Alcohol/Drug Abuse Treatment/Referral □ HIV/AIDS-related Treatment
□ Sexually Transmitted Diseases □ Mental Health (Other than Psychotherapy Notes)
□ I specifically do NOT want information released concerning: _____

Patient Signature: _____ **Date**: _____
I have read this form in its entirety, and completely understand my rights and financial obligations.

Signature of Parent or Legal Guardian: _____ **Date**: _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire one year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Administrator in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation.

- I understand that under the applicable law the information used or described pursuant to this authorization any be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Unified Women's Health is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that I used or disclosed.