Authorization for Disclosure of Health Information

I, the undersigned, authorize Unified Women's Health of the Carolinas (d.b.a. **ARBOR OBGYN**) to release my health information.

Please fax, mail, or hand-deliver this completed authorization form to Arbor ObGyn.
2615 Lake Drive, Suite 201, Raleigh, NC 27607
phone: 919-781-9555 **fax: 919-781-**1070 www.arbor-obgyn.com

***** All sections must be legible & complete for request to be processed *****
This authorization form may accompany your medical records.

Patient Information:

Patient Full Name: _____ Other Names during Treatment: _____

Patient Address: _____ Mobile Phone: (_____)_____-_____

City: _____State: _____ Zip: _____ Record Number (if known): _____

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:

Note that records released may be limited to care provided by, or tests ordered by Arbor ObGyn.

□ ENTIRE RECORD □ Current Prenatal Records □ Labs □ Imaging □ Surgery Notes □ Office Visits

□ Specific information: _____

** Specify Dates of Records to be released: _____/_____/_____ to _____/_____/_____

North Carolina Statute §90-411: You may incur the **costs for searching, handling, copying, and mailing medical records. The maximum fee for each request is 75¢ per page for the first 25 pages, 50¢ per page for pages 26 through 100, and 25¢ for each page more than 100 pages; with a minimum fee $10.00. Charges outlined above will be applied for all copies released directly to the patient or sent on the patient's behalf. Your account will be billed, and payment must be made prior to release of records. You understand that medical record processing may be outsourced to a professional Health Information Handler (HIH), and that you will receive an invoice and make payment 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 DO NOT want the following sensitive information disclosed, check the applicable box(es):
□ Alcohol/Drug Abuse Treatment/Referral □ HIV/AIDS-related Treatment
□ Psychiatric or Psychotherapy treatment
□ I specifically do NOT want information released concerning: _____

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 my health care provider cannot guarantee the recipient will not redisclose my health information. I understand that signing this authorization is voluntary and will not condition my treatment, payment, enrollment or eligibility for benefits.

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