WENDOVER
OB/GYN & INFERTILITY

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Authorization to Disclose Protected Health or Billing Information Request

I give Permission to release the health information of:

Patient Name_____ DOB_____

Street Address_____

City, State, Zip Code _____ Phone #_____

Release Information:

From _____	**To** _____
Name_____	**Name** _____
Address _____	**Address**_____
Phone #_____	**Phone #** _____
Fax # _____	**Fax #** _____

Purpose of Release (check reason): ❑ Request of individual/personal ❑ Insurance ❑ Disability

❑ Transfer ❑ Legal ❑ Continuation of Care ❑ Other:_____

Please Send (check reason):

❑ All Records (including visits/imaging/labs) ❑ Specific Date(s) of Service_____to_____

❑ Office Notes _____ ❑ Specific Imaging_____

❑ Specific Labs _____ ❑ Other_____

I understand that I am authorizing the release of all medical information from my medical record unless specifically restricted as indicated below **(you must initial if you want any restrictions, no check marks):**

_____HIV/AIDS or related testing _____Mental Health _____Chemical Dependency (drug/alcohol)

This authorization is valid for 180 days from the date signed or until whichever is shorter. This authorization may be revoked at any time by notifying Wendover OB-GYN in writing, except when this authorization was obtained as a condition of acquiring life insurance coverage. Information used/disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected.

Signature of Patient or Legal Representative_____ Date_____

Print Name_____

Relationship of Representative to Patient_____

Relationship to Patient, if not the Patient_____