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INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: **NORTH PARK OBGYN** to release, use or disclose information from the health record of:

Patient Name: ________________________________ **Date of Birth:**__________________
Address: ____
City: __________________ **State:** __________ **Telephone:** ____________________________
Social Security: _________________________

Covering the period(s) of health care from: ______________ to: _____________
The following:

___COMPLETE MEDICAL RECORD(S)
___DISCHARGE SUMMARY
___HISTORY & PHYSICAL EXAM
___ORDERS & PROGRESS NOTES
___X-RAY REPORTS
___PATHOLOGY
___LABARATORY TEST
___CONSULTATION REPORTS
___OPERATIVE REPORTS
___OTHER (SPECIFY)

The information will be used or disclosed for the following purpose(s):
___ To assist in the provision of services, care, and treatment of the individual
___ At the request of the individual
___ Other (specify)

RELEASE RECORD TO: __________________________________
ADDRESS:____
PHONE NUMBER:____________ **FAX NUMBER:** _____________

You have the right to revoke this authorization by doing so in writing and mailing to the above address. Such revocation will be effective to the extent that action has not been taken in reliance on the authorization, or if the insurer with the right to consent a claim under the policy. The information used or disclosed under the under the authorization may be subject to re- disclosure by the recipient and may no longer be protected by the regulation that protect individually identifiable health information from use or disclose by health care providers. *I UNDERSTAND I MAY INSOECT AND/OR COPY THE SIGNED DISCLOSURE OF PROTECTED HEALTH INFORMATIN FORM.*

Signature: ________________________________ **Date:** ________________________

Expiration Date: 1 year from the signature date.