

Genesee Valley Obstetrics and Gynecology, P.C.

990 South Avenue, Suite 103 Rochester, N.Y. 14620 Phone (585) 232-3210 Fax (585) 232-4657

21 Willow Pond Way, Suite 100 Penfield, N.Y. 14526 Phone (585) 641-0399 Fax (585) 641-0388

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

For a permanent transfer of records, there will be a charge of **\$.75 per page** for copying and administrative costs. *This fee will not exceed \$25.00.* We will not fax medical records unless it is an emergent situation.

Patient's Name (please print) _____	Date of birth _____
Address _____	
Phone (____) _____	SS# _____

I authorize Dr. _____ of Genesee Valley Ob/Gyn, PC to take the following action:			
<input type="checkbox"/> Release Information to:	OR	<input type="checkbox"/> Obtain information from:	
Dr. _____ Office Phone _____			
Address: _____			
	<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip Code</i>

❖ Purpose and Need for release
<input type="checkbox"/> Treatment <input type="checkbox"/> Legal Services <input type="checkbox"/> Insurance Coverage <input type="checkbox"/> Personal <input type="checkbox"/> Other

❖ This information may be released by: <input type="checkbox"/> Copy <input type="checkbox"/> Fax (Urgent/Emergent situations only) <input type="checkbox"/> Verbal

❖ I authorize the release of the following Protected Health Information (PHI) and/or medical records, if such information exists:
<input type="checkbox"/> All Information (The request to send all medical information will include the release of HIV/AIDS and/or sexually transmitted disease- related and/or psychological or psychiatric treatment and/or drug/alcohol abuse treatment information. I understand that this serves as a dual release inclusive of sensitive medical information, including HIV unless otherwise requested.
<input type="checkbox"/> All Information with the following exceptions (Please specify) _____

OR (Select desired information to be released)
<input type="checkbox"/> Annual Exam Notes <input type="checkbox"/> GYN Exam Notes / Assessments <input type="checkbox"/> Prenatal Records
<input type="checkbox"/> Diagnostic / Lab test results <input type="checkbox"/> Operative Report <input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Other _____

❖ **This Authorization covers treatment Period(s)** *(Please select "All" or specific treatment dates)*
 All episodes of care **OR** From _____ to _____
 From _____ to _____

❖ **This Authorization expires (date or Event)** _____
Note: If no date is noted, this authorization will expire **one year** from the date it was signed.

- ❖ **I understand that:**
- My right to healthcare treatment is not conditioned by this authorization.
 - I may cancel (revoke) this authorization at any time by submitting a request to our office. I understand that the cancellation will not apply to information already released in response to this authorization.
 - If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations, this information could be re-disclosed.

- I **am not** transferring my care to this physician/facility on a permanent basis.
- I **am** leaving Genesee Valley Ob/Gyn, PC and transferring my care to this physician/facility permanently.

In order to better serve our patients, your feedback is appreciated.

Reason for transferring from practice:

- Moving Insurance Dissatisfied Other, please specify: _____

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Signature of patient or legal patient representative _____

Date _____

If the above signed is a legal patient representative:

Print Name _____ **Phone Number** _____

Relationship to Patient _____

Witness (Optional) _____ **Date** _____

GVOG Use Only

Date Information was forwarded _____

GVOG Staff member who addressed request to release information _____