

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the Highland OB/GYN Clinic, PA, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient Name: _____ Phone Number:

Address:

_____ (Street) (City) (State) (ZIP Code)

Date of Birth: _____ Medical Records #:

Release information to: (Please check appropriate box below)

Highland OB/GYN Clinic, PA, 2301 Robeson Street Suite 201, Fayetteville, NC 28305 /Fax: 910-485-6006

Requesting records from:

Office # _____ Fax # _____

(Name of individual or organization) (Street), (City, State, Zip) (Phone Number) (Fax Number)

_____ Patient Pick-up

Initial all that apply:

I am requesting the following information to be released:

_____ Abstraction of record (includes: Operative reports, consultations, laboratory findings, and other significant findings)

Date(s) of Treatment: _____

_____ Entire medical record

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment released to physician (name)

_____ Litigation for review (name of Legal firm)

_____ Personal release

_____ Insurance (company name):

_____ Other: Specify Reason:

*This consent permits Highland OB/GYN Clinic, PA to use and disclose my health information to carry out treatment, payment, or health care operations. Additional information regarding the uses and disclosures of health information is described in the Highland OB/GYN Clinic, PA notice of privacy Highland OB/GYN Clinic, PA. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and health care operations purposes. However, the Highland OB/GYN Clinic, PA are not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby **RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE** Highland OB/GYN Clinic, PA, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.*

_____ (Print Patient's Name)

_____ (Signature of Patient) Date:

_____ (Signature of Legally Authorized Person)

**I am aware that there are potential fees for release of medical records, etc. A request may take 5-7 working days to process. If you do not receive the records within 5-7 days, you should call Medical Records Department at 910-485-1191.