OAKBEND MEDICAL GROUP

Patient Request for Access to Protected Health Information

Contact Information

Name of Patient _____ Date of Birth _____

Address _____ Phone _____

City, State, Zip _____

Dates of Service _____ Date Information Needed _____

_____

Mail Copies to: ☐ Address listed above ☐ Address listed below

Address _____ Phone _____

City, State, Zip _____

Authorization

I authorize OBMG to disclose the protected health information about myself (or the patient) as described above.
I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
  Expiration _____
- I may revoke this authorization at any time by notifying OBMG in writing. If I revoke the authorization, I understand that it will have no affect on actions OBMG took in good faith before receiving the revocation.
- The information released my contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- OBMG may not condition treatment or payment on my completion of this form
- OBMG reserves the right to verify my identity or guardianship.
- I will be charged for the copies requested.

Signature _____ Date _____

Printed Name _____ Relationship to Patient _____

Reason for Transfer

Please indicate the reason why you are transferring out of our practice.

☐ Moving out of the city or state
☐ Practice does not accept insurance
☐ Dissatisfied with care

Thank you for choosing OakBend Medical Group.