



This completed form authorizes a third party to disclose a patient's protected health information to OakBend Medical Group.

### Authorization for Disclosure of Protected Health Information

#### Patient Contact Information

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address (City,State,Zip) \_\_\_\_\_ Phone \_\_\_\_\_  
Dates of Service \_\_\_\_\_

#### Reports to be Disclosed

Please indicate those reports that you would like to be disclosed.

History and Physical Exam \_\_\_\_\_ Growth Chart \_\_\_\_\_  
Consultation Reports \_\_\_\_\_ Operative Reports \_\_\_\_\_  
Progress Notes \_\_\_\_\_ Billing Claim Forms \_\_\_\_\_  
Radiology Reports \_\_\_\_\_ Itemized Statement of Charges \_\_\_\_\_  
Laboratory Reports \_\_\_\_\_ All Information \_\_\_\_\_  
Pathology Reports \_\_\_\_\_ Other \_\_\_\_\_  
Immunization Records \_\_\_\_\_

#### Records Released From

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Fax \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_

#### Records Released To

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Fax \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Reason for record release \_\_\_\_\_

#### Authorization

I authorize the third party named in the above section to disclose the protected health information about myself (or the patient) as described above.

- 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 may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- OBMG may not condition treatment or payment on my completion of this form.
- OBMG reserves the right to verify my identity or guardianship.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Printed Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

Thank you for choosing OakBend Medical Group