Bloomington Obstetrics & Gynecology
421 West First Street
Bloomington, IN 47403
812-336-0168
812-335-7372 Fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Date _____ SSN _____

Patient Name _____ Date of Birth _____

Address _____ Phone Number _____

1) I, _____ hereby authorize _____

to release the following from my medical record:

_____ Only the following tests or records:

_____

_____

_____ Complete Medical Record (which may include mental and psychiatric health; drug or alcohol abuse; human immunodeficiency virus (HIV); Acquired Immunodeficiency Virus (AIDS); and AIDs related complex (ARC); Genetics testing and genetics counseling).

I understand I am not required to release genetic testing or counseling results.

_____
Patient's Signature

2) Release the Above Information to:

Name: _____

Address: _____

City/State/Zip: _____

3) Purpose of the release: _____

4) I agree to pay Bloomington Obstetrics & Gynecology the actual cost incurred, if any, in preparing the copy of the requested record.

Charges for records release:

a) For 1-10 pages - $15 retrieval fee
b) 11 or more pages - $15 retrieval fee plus 25¢ per page, beginning with page 11
c) Provider may additionally collect any postage
d) If patient requests and records are provided within 2 working days, provider may collect an additional $10 fee

5) This request is good for 60 days unless I revoke it by writing before such time.

_____ _____ _____ _____
Patient's Signature date Witness date