OBGYN ASSOCIATES

605 N Cleveland Massillon Road, Akron, OH 44333
Phone: 330-668-6545 Fax: 330-668-2726

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

NAME: _____ Date of Birth: _____

I hereby authorize: _____
Practice/Facility/Physician Name

_____
Phone/Fax/Address

To release information from my medical record to:

_____
Practice/Facility/Physician Name

_____
Phone/Fax/Address

At this time, I am requesting that the following information be released (check all that apply):

_____ Transfer of care to another provider, practice name or provider listed above.
_____ Continuation of care or consultation with a specialist, practice name or provider listed above.
_____ To Establish a primary care physician, practice name or provider listed above.
_____ Personal Use
_____ Insurance, FMLA, disability claim (insurance company or work FMLA recipient listed above)
_____ Other: please specify:_____
_____ My Complete Medical Records, last 2 years unless specified otherwise; including but not limited to, office notes, consultation and operative reports, medication history, phone call documentation, laboratory and imaging reports
_____ Complete Records of my medical care for the following specified dates of treatment:
From: _____ To: _____

_____ Records of my medical care for the following medical condition(s) only:

_____

I hereby give consent for the specific release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, along with the rest of my medical records.

SIGN: _____ DATE**:** _____

I understand by signing this request that Ob/Gyn Associates of Akron, Inc., is not responsible for lost, misplaced or stolen medical information/records once they are released.

I also understand by signing this request that Ob/Gyn Associates of Akron, Inc., in accordance to federal and state regulations, may charge a reasonable fee for copying your records and may also additionally charge for postage if you request that your records be mailed to you.

I understand that once I sign to have my records transferred from Ob/Gyn Associates of Akron, Inc., There will be a cost associated with it, if it is going to an entity that is not for my continued medical care with a healthcare professional. This cost is compliant with Ohio Law 3701.742
$3.11 per page for the first 10 pages, 65 cents per page for pages 11-50, and 26 cents per page for pages 51 and higher.

I understand in accordance with federal law and HIPAA regulations that Ob/Gyn Associates, Inc., has thirty (30) days to process my request for medical records and release of information, and that at times with documentation of necessity, we can request an additional thirty day amendment to process the request if/when needed in certain circumstances.

I understand that this authorization for the release of medical information will expire within twelve (12) months of the original signature date unless otherwise indicated here: Expiration Date: _____ Initials: _____

Signature: _____ Today's Date: _____

Printed Name (first and last): _____