Fairhaven Obstetrics & Gynecology, Inc. **Phone: 574-533-0348**
1111 Lighthouse Lane, Goshen, IN 46526 **Fax: 574-533-0277**

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Name:____Phone (_____)_____________Previous name, if different from now__________________

Address____ Birth Date_______________________________________

City_______________________________________ State___________ Zip__________ SSN:____

Send information to:

Name_______________________________________

Attention___________________Phone___________

Address_____________________________________

City__________________State_____Zip_________

Request information from:

Name_____________________________________

Attention__________________Phone___________

Address_____________________________________

City_______________State______Zip__________

This authorization shall remain valid for sixty (60) days from the date of signature. This authorization will expire on (specific event/date)___________________________. I understand that I have the right to revoke this Authorization if the revocation is in writing, except if:
*Fairhaven Obstetrics & Gynecology, Inc. has already acted on this Authorization:
*Or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that I may revoke this Authorization by submitting my request in writing to Fairhaven Obstetrics & Gynecology, Inc. at the above address. I understand that the medical information released may contain information concerning the treatment of physical or emotional illness, drug and/or alcohol abuse, mental health, communicable disease, HIV, AIDS, or AIDS related illness.

I understand that my health information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my information will no longer be protected by the General Privacy Regulations.

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

I understand that there is a charge for copying medical records at $20.00 for the first ten (10) pages, .50 cents for pages 11-50, and .25 cents for pages 51 and higher plus postage. These charges do not apply to copies being requested for further medical care. If the request is needed with (2) days, $10.00 may be charged for expediting the process.

INFORMATION TO BE RELEASED

__Partial Chart (includes all physician dictation and all test results)
__Entire Chart (all health information)
__Face Sheet
__Discharge Summary
__History & Physical
__Consultant Report(s)
__Emergency Room Report(s)
__Other____
__Radiology Report(s)
__Operative Report(s)
__Laboratory Report(s)

REASON FOR DISCLOSURE- This information will be released for the following purpose:

__Personal Use
__Attorney/Legal
__Continuing Patient Care
__Other____
__Insurance

SIGNATURE

Signature of Patient____Date____________________________________

Printed____Witness____

Signature of Parent (if patient is under 18) or Authorized Legal Representative_______________________________Date______________________