Hilltop Obstetrics & Gynecology
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Authorization to Transfer Records

I, the below identified person, do hereby authorize the release of my medical records, as indicated herein, between the following parties:

Records From or To (must circle one):______________________
____
____
Phone Number:______________________
Fax Number:______________________**(must be provided)**

I direct that all information obtained in association with this release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific authorization. However, I understand that this authorization is voluntary and that I may refuse to sign it. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for ninety (90) days from the date of my signature unless I specify an earlier expiration dated in this space___________. I understand that, except to the extent the action has been taken based upon my authorization, I may withdraw this authorization at any time by written notification to the parties involved. This authorization in no way negates the ability of the above named practice to carry out any communication that may be necessary for patient continuity of care with another provider, nor does it replace the Hilltop Obstetrics & Gynecology Patient Privacy Acknowledgement form (Patient Consent for Use and Disclosure of Protected Health Information). This authorization further permits the above entities to use and /or disclose, or re-disclose information from the records as specified below. Such authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s). I understand that I may be charged the amount allowed by Ohio Law under ORC3701.74.

Patient Name: ____
Date of Birth: _________________________Telephone number: ________________________
Address: ____
City: ______________________State:__________________ Zip Code:______________________

Purpose for release:____

It is my desire that only the following information indicated below be released as a result of this authorization. Date(s) of treatment to be released:_________________________________

_______ Copy Entire Record
_______ Patient information Form
_______ History & Physical
_______ Discharge Summary
_______ Lab/Pathology/Radiology reports
_________ Operative Report
_________ Consultation(s)
_________ Progress Notes
_________ Emergency Department Records
_________ Other (please specify)__________________

I understand that this consent is to include disclosure of: (please initial each)

______Alcohol/drug abuse
______ Sexually transmitted disease information
______ Psychiatric records
______ HIV/AIDS information

I hereby state that I have read and fully understand the above statements as they apply to the named patient. I hereby consent to the release of medical information. Any further disclosure of this information is prohibited unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as permitted by law. A photocopy of this authorization is to be accepted the same as the original.

Signature of Patient/Guardian:____Date________________________________

Witness:____Date:________________________________