

**WESTERN OB/GYN LTD.
PRACTICE OF
OBSTETRICS AND GYNECOLOGY**

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birthdate: _____
Address: _____ Day Phone #: _____
City/State/ZIP: _____

Facility That Has Your Medical Information:	Disclose Information TO:
Facility Name _____	Facility Name _____
Address _____	Address _____
_____	_____
Phone # _____	Phone # _____
Fax # _____	Fax # _____

Information to Be Released:

<input type="checkbox"/> Pregnancy Records	<input type="checkbox"/> Provider Notes	<input type="checkbox"/> Mammogram
<input type="checkbox"/> Bone Density Reports	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Perinatology	<input type="checkbox"/> Research Records	<input type="checkbox"/> Semen Analysis
<input type="checkbox"/> Ultrasound Reports	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Itemized Bills
<input type="checkbox"/> Disclosure to RMC	<input type="checkbox"/> Other _____	

Any medical information that was not originally generated by Western OB/GYN Ltd. will not be released. That information must be requested from that facility.

Limit Records to: _____ Time period from: _____ to: _____

Information needed by (date) _____

Purpose of Disclosure:

At the request of the patient Transfer to new physician Insurance claim/Life insurance Legal
 Disability Other _____

This authorization **will expire one year** from the date of signature or on: _____
I understand that I may revoke this authorization at any time by sending written notice to the health care facility noted above. I hereby authorize the above facility to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To." I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may be charged in accordance with state and federal statutes for the processing of the requested records.
This information must be filled out completely.

Signature of Patient or Representative

Date