

Kingsdale Gynecologic Associates

A Division of MaternOhio Clinical Associates, Inc.

1315 West lane Avenue

Columbus, Ohio 43221

Fax (614) 326-0250

MOCA

MaternOhio Clinical Associates, Inc.

Authorization for release of protected Health Information

Patient Name: _____

Date of Birth: _____

Patient's Physician: _____

Telephone: _____

Address: _____

Information Requested

Entire Medical Record: Yes ___ No ___ If no, please specify documents or dates of service: _____

I would like copies of my health information indicated in the section above sent:

From: _____

To: _____

I authorize the release of health information contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statute and Ohio Department of Public Health rules, which include venereal disease, Tuberculosis, Hepatitis A,B,C, Human Immunodeficiency Virus (HIV), HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS), and AIDS related complex (ARC) and _____(specify).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, part 2.
- Mental health treatments records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Purpose of Disclosure: (circle one)

Attorney / Legal

Continued Patient Care

Insurance

Personal Use

Disability

Other: _____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization, or person. I further understand that correspondence, patient discharge instructions and records from healthcare providers other than MaternOhio Clinical Associates, Inc will not be released unless specifically requested above.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it.

- This authorization will expire 60 days from the date signed.
- Please allow 7-10 business days for processing.

I understand that health Information that is released under this authorization may be subject to re-disclosure by the recipient, and the privacy of my Health Information may no longer be protected by the law.

*A faxed copy of this authorization shall have the same effect as the original.

A \$15 fee is due upon request or receipt if records are copied for the patient. If records are copied for another physician's office / hospital, there is no charge.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness

Date

ID Checked: _____