UNIVERSITY OBGYN ASSOCIATES

725 Irving Avenue, Suite 600, Syracuse, NY 13210
Phone: 315-464-5162 Fax: 315-464-2122

Authorization for Release of Health Information

Form must be filled out completely to avoid delays in fulfilling request

Print Patient Name_____ **Birthdate**_____

Social Security XX-XX-_ _ _ _

Address _____ **Phone**_____

From:

The Hill OB-GYN Associates, P.C.
1000 E Genesee Street – Suite 600
Syracuse, NY 13210
Phone: 315-471-2713

To:

University OB/GYN Associates
725 Irving Avenue – Suite 600
Syracuse, NY 13210
Phone: 315-464-5162
Fax: 315-464-2122

Description of information that may be disclosed:

- [ ] **All Records**
- [ ] Mental Health Information
- [ ] HIV-Related Information
- [ ] Surgical Notes
- [ ] Other (please specify)_____
- [ ] Office Notes
- [ ] Lab Reports
- [ ] Imaging Reports

The information will be used for the following purposes:

- [ ] Transfer of Care
- [ ] 2nd Opinion
- [ ] Moving out of area
- [ ] Personal File

I, or my authorized representative, authorize the release of my protected health information as indicated and requested above.

I understand that I may revoke this authorization in writing at any time by submitting documentation to the practice except to the extent that the action has been taken in reliance on this authorization. This authorization expires 90 days from the date signed unless otherwise directed.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Representative **Relationship**