AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name:		Date of Birth:	
Address:	City:	State:	Zip Code:
Social Security Number:	Maiden Name:		
Other Names Used:		Phone:	

I HEREBY *authorize medical information regarding the above identified person to be released*

From:	**Send To:**
	OB/GYN Associates, P.A. dba **OGA**
	3520 E Louise. Drive, Meridian, Idaho, 83646
	Office (208)888-0909 fax (208)888-5825

Reason for Request: _____

Approximate Date of Care From: _____ To: _____

Records Requested: _____

I understand this request will include medical information only from the provider listed above.

PATIENT MUST INITIAL EACH BOX TO BE VALID AND PROVIDE PHOTO ID

☐ ***Alcohol***

☐ ***Drug Abuse Records***

☐ ***AIDS Diagnosis***

☐ ***HIV Tests***

☐ ***Psychiatric/Mental Health Records***

☐ ***Other***: _____

PLEASE SEND MEDICAL INFORMATION TO OGA BY: ☐ MAIL ☐ FAX

I hereby consent to the release of the above information obtained in the course of my diagnosis and treatment. This authorization is valid for six (6) months from date of signature unless previously revoked in writing. Any re-disclosure of information obtained by this authorization is prohibited.

Print Name: _____

Signature: _____ Date: _____

Parent or Guardian Name (if patient is minor): _____

Parent or Guardian Signature: _____ Date: _____

SUBMIT FORM TO OGA: ☐ MAIL ☐ FAX: 208-888-5825 ☐ EMAIL: MR@OGAIDAHO.COM

3520 E. Louise Drive
Meridian, ID 83642
(208) 888.0909 phone
(208) 888.5825 fax

9850 W. St Luke's Drive, Ste. 221
Nampa, ID 83687
(208) 455.1784 phone
(208) 465.3636 fax

3101 E. State Street, Ste. 2100
Eagle, ID 83616
(208) 938-2220 phone
(208) 938-2235 fax

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