Authorization to Obtain Medical Records

Patient name: Date of birth:

Address:

City: State: Zip:

Other names used: Phone:

I hearby authorize medical information regarding the above person to be released:

FROM:		TO:	OB/GYN Associates (dba **OGA**)
			3520 E. Louise Dr.
			Meridian, ID 83642
			ph: 208-888-0909 fax: 208-888-5825
			email: mr@ogaidaho.com

Approximate dates of service: **FROM:** **TO:**

Reason for request:

Records requested:

___ Labs ___ Prenatal records ___ Operative Notes _____
___ Pathology ___ Progress notes ___ Other: _____
___ Imaging ___ Delivery notes ___ All records

Additional records: Patient must initial each category to be valid.

_____ Alcohol _____ AIDS diagnosis _____ Psychiatric/Mental health
_____ Drug abuse _____ HIV testing _____ Other: _____

I hearby consent to the release of the above information obtained in the course of my diagnosis and treatment.
This authorization is valid for 6 months from the date of signature unless previously revoked in writing.
Any re-disclosure of information obtained by this authorization is prohibited. ***Form invalid without signature.***

Print patient name:

Patient signature: Date:

Parent or guardian (if patient is minor):

Parent or guardian signature: Date:

Forms can be submitted by **fax** (**208-888-5825**) or email (**mr@ogaidaho.com**) or mail.

Staff signature: Date:

Scanned to med recs date: Faxed date: