Authorization to Release 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 Drive	
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.***
This authorization is for care received by OGA only. Records for care received outside of OGA will need to be specified by patient or those facilities/clinics directly.

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 Medical Records: ____________________ Faxed: ____________