

Tri-State Maternal-Fetal Medicine Associates, Inc.
375 Dixmyth Avenue, Cincinnati, Ohio 45220
Phone: (513)862-6200 Fax: (513)862-4352

Authorization for Release of Protected Health Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____
(Please Print)

Social Security #: _____ Daytime Phone#: _____

Information Released To:

From:

Please Release the Following:

<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Medication List	<input type="checkbox"/> Admission & Discharge Summary
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Delivery & Obstetric Discharge Summary
<input type="checkbox"/> Prenatal Record / ACOG	<input type="checkbox"/> Operative Report (Date: _____)
<input type="checkbox"/> X-ray, CT, U/S, MRI, Echo, NST Reports	<input type="checkbox"/> Emergency Department Record
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Nuclear Medicine Reports
<input type="checkbox"/> Other: _____	

Including Information Pertaining to:

Mental Health Drug/Alcohol HIV/AIDS Communicable Treatment

Purpose of Need for Disclosure:

<input type="checkbox"/> Continued Patient Care	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Attorney/Legal	<input type="checkbox"/> Insurance Claim/Application
<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Other (Specify) _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it, by sending a letter to Tri-State Maternal-Fetal Medicine Assoc. Inc, c/o Practice Manager, 375 Dixmyth Avenue, Cincinnati, Ohio. . This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness

Date request completed _____ # pages copied _____ Initials _____