MADISON
OB/GYN Associates

MEDICAL RELEASE OF INFORMATION TO A FAMILY MEMBER

Patient Name: _____ Date of Birth: _____

We are asking our patients to complete this Medical Release of Information in order for us to be able to discuss Billing and/or Clinical information to family members. **PLEASE COMPLETE ONLY ONE SECTION.**

DO NOT RELEASE ANY OF MY INFORMATION

☐ I DO NOT want any of my medical information including billing information released.

Patient Signature: _____ Date: _____ MOA Staff: _____

OR

COMPLETE THIS SECTION TO RELEASE INFORMATION TO A FAMILY MEMBER

Name/Relationship: _____ Date of Birth: _____

Name/Relationship: _____ Date of Birth: _____

Please identify the information to be released:

☐ Please release my entire record including billing information.

☐ Please release **only** the following information: ☐ Office Notes ☐ Lab Results ☐ Surgery Notes

☐ Prenatal Records ☐ Ultrasound & Imaging report ☐ Billing Information

Please initial each item below to indicate your understanding. (PLEASE READ IN ITS ENTIRETY.)

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary.

Patient Signature: _____ Date: _____ MOA STAFF: _____