Wilmington Maternal-Fetal Medicine

AUTHORIZATION FOR OBTAINING AND DISCLOSING PROTECTED HEALTH INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Authorization for Medical Records to be Released from: _____

Address:_____

Phone: _____ Fax:_____

Medical Records to be Released to: _____

Address:_____

Phone: _____ Fax:_____

This authorization will expire on the following date: _____

Purpose of Disclosure: ☐ Medical Records ☐ Other: _____

Will the recipient receive direct/indirect payment in exchange for using this information for marketing? ☐ Yes ☐ No

Will the recipient receive financial or in-kind compensation in exchange for the sale of this information? ☐ Yes ☐ No

Description of information to be used or disclosed:

- ☐ Consultation Report
- ☐ Ultrasound Report
- ☐ Laboratory Results
- ☐ Genetic Testing Results
- ☐ Operative Report
- ☐ All PHI in medical record
- ☐ Other: _____

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on the actions taken in reliance on this authorization prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is no a health plan, healthcare provider, healthcare clearing house or business associate of such health plan, healthcare provider or healthcare clearing house the released information may no longer be protected by federal policy regulations and may be disclosed.
- I understand that I may see and obtain a copy of the information described in this form if I ask for it.
- I may receive a copy of this form after signing it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative: _____

Printed Name of Patient/Patient Representative:_____

Date:_____ Relationship to Patient: _____

Indicate authorized representative's authority to act on the patient's behalf: ☐ Parent/Legal Guardian ☐ Power of Attorney