Authorization for Release of Medical Information - OB Transfers

Patient's Full Name: ____ **Date of Birth:** ______________

Street Address: ____ **Apt/Unit Number:**____________

City: ___________________________ **State**_________ **Zip Code:** __________ **Phone:** ____________________

Email address: ____

I hereby request and consent to the release and disclosure of my personal health information to the below named physician or organization.

INFORMATION RELEASED TO:

Cary OB/GYN
Attn: OB Coordinator
550 New Waverly Place, Suite 200
Cary, NC 27518
Phone: 919-467-5941
Fax: 919-655-0532

I authorize the following information to be sent to the medical provider listed above:

____ Demographics Sheet (to include insurance information)
____ Last 3 Pap results
____ OB records for current pregnancy (Original lab reports and Ultrasound reports)
____ Any c-section or uterine surgery operative notes

Reason for records request: Transferring OB care to Cary OB/GYN

INFORMATION RELEASED FROM:

____
Name of Practice or Provider

____
Street Address including Suite #

____
City, State, Zip Code

____
Phone **Fax**

This authorization is valid for 12 months form the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.

Patient / Guardian Signature: ____ **Date:** _____/_____/_____

NOTE: THERE MAY BE A CHARGE FROM THE FACILITY RELEASING THE RECORDS AND YOU MAY BE BILLED DIRECTLY FOR THE SERVICE. PLEASE CONTACT THAT FACILITY IF YOU HAVE ANY QUESTIONS REGARDING THEIR POLICY.