

## AUTHORIZATION FOR RELEASE OF INFORMATION – OB RECORDS

I hereby authorize **Arizona OBGYN Affiliates** (Maricopa OB/GYN Division) to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand copies of records received from other health care providers may not be released.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g., insurance company or health care provider; the released information may no longer be protected by Federal and State privacy regulations. I also authorize the release of records by fax transmission and agree to hold **Arizona OBGYN Affiliates** (Maricopa OB/GYN Associates) harmless for errors in receipt of transmission.

I hereby authorize the release of my prenatal records to Banner Good Samaritan Regional Medical Center.

I understand that I may revoke this authorization at any time by notifying Arizona OBGYN Affiliates in writing. I understand the written revocation must be signed and dated with a date that is later than the date of this authorization.

PRINT PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

Signature of Patient or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

If other than patient, print name here \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Legal Authority (attach supporting documentation) \_\_\_\_\_

Witness Signature \_\_\_\_\_