Ramapo Valley OB/GYN, P.C.
974 Route 45, Suite 1000, Pomona, NY 10970
Phone: 845-354-1113/ Fax: 845-354-1813
Web Site www.ramapovalleyobgyn.com

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 7-10 business days for copying. There is a fee of 75 cents per page for copies of medical records. The medical records cannot be released until this form is completed and signed by the patient or legal guardian.
You must complete this form thoroughly.

PLEASE PRINT
Step I: Patient Name_____ Date of Birth _____

Address _____
Street City State Zip Code

Step II: I hereby authorize Ramapo Valley OB/GYN, P.C:

_____To release my health information _____To obtain my health information.

Name of Physician/Medical Facility_____

Address _____
Street City State Zip Code Phone # Fax #

Step III: Information to be released: _____
Date (s)/Condition (s)

____Transferring out of the practice Reason: _____
(This section must be completed before records will be released)

____2nd Opinion/will be continuing care with the practice

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the healthcare provider listed above.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
This authorization is valid for 90 days for the release of information as indicated above. Only records from this facility can legally be released. Any records from other physicians must be obtained from them.

_____ _____
Patient Signature & Date Parent/Guardian Signature & Date

_____ _____
Witness Signature & Date Physician Signature & Date

Date Copied_____ #Pages Copied_____ Copied By_____

Signature at Pick Up: _____ Mailed:_____ Faxed:_____