SRMC
SOUTHSIDE REGIONAL
PHYSICIANS NETWORK

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

_____ _____ _____
Patient's Full Name | Social Security Number | Date of Birth

I, _____, authorize the use and disclosure of health information about me as described below:
Patient's Full Name

Health information that may be used/disclosed is limited to the following:

___ Discharge Summary ___ Pathology Reports ___ Emergency Reports

___ Laboratory Reports ___ Radiology Reports ___ Progress Notes/Office Visits

___ ECG/EKG/Cardiac Cath Reports ___ Other _____

___ I do ___ I do not authorize the release of information related to AIDS, HIV, psychiatric care, and/or psychological assessment and treatment for alcohol and/or drug abuse.

_____ _____
Facility Authorized to Release Health Information | Telephone Number

_____ _____
Address | Fax Number

Information Release to: Tri-Cities OB/GYN Associates
Drs. Baker, Bazile-Harrison, Kudaravalli & Meyers
210 Medical Park Boulevard, Suite 150
Petersburg, VA 23805
Phone: 804-765-5206 or Fax: 804-765-5809

PURPOSE OF DISCLOSURE:

___ Referral Specialist ___ Insurance ___ Workman's Comp ___ Personal

___ Legal Investigation ___ Disability ___ Change of Doctor

___ Other (be specific) _____

Please provide a current phone number in the event that someone needs to contact you: _____

I hereby authorize disclosure of the health information of the above named patient. The authorization is valid 12 months from the date of the signature. I hereby authorize that I may cancel the request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that this medical facility will not condition its treatment of me on whether or not I sign this authorization.

_____ _____
Patient's or Authorized Representative's Signature | Relationship

_____ _____ _____
Witness' Signature | Date | Time