LEXINGTON OB GYN
Associates

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1700 Nicholasville Road, Suite 701 • Lexington, KY 40503
Phone: (859) 278-0396 • Fax: (859) 277-5414 • www.LexingtonObGyn.com

Authorization to Release Protected Health Information Records

Patient's Name : _____
Address : _____

_____
Date of Birth SSN PH #

I hereby authorize and request :
Lexington OB GYN Associates 1760 Nicholasville Rd., Ste 101 Lexington, KY 40502
Phone : 859-278-0396 Fax : 859-276-1168

To share the following items from my Protected Health Information

_____ Physician Notes/Records _____ Pap Smears/Biopsies
_____ Laboratory Tests _____ Operative Reports
_____ All Records _____ Other (Please List) : _____
Dates of Treatment : _____

With : _____
Name of organization or MD

_____
Street City State Zip

_____
Phone Number Fax Number

The sharing of this information is for:

_____ Coordinated care with another MD _____ Transfer of care to another MD
_____ Patient's personal records _____ Insurance clarification
_____ Legal proceedings _____ Other (Please List) : _____

I understand I may refuse to sign this authorization.

I understand I may revoke this authorization, at any time, if requested in writing to Lexington OB GYN Associates, except if Lexington OB GYN Associates has taken action based on my authorization; or obtained my authorization for the purpose of receiving reimbursement from a third party payer.

Unless previously revoked, this authorization shall expire one year from the date or signature or at a designated time listed : _____

_____ _____
Date Signature

_____ _____
Date Witness

Release FROM Lexington ob/gyn