LEXINGTON OB GYN
Associates

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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 :

____
Name of organization or MD

____
Street | City | State | Zip

____
Phone Number | Fax Number

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 :

Lexington OB GYN Associates | 1760 Nicholasville Rd., Ste 101 | Lexington, KY 40502
Phone : 859-278-0396 | Fax : 859-276-1168

I understand that sharing of this information is for: _____ Continued Care _____ Insurance
_____ Patient Request _____ Attorney/Court Request _____ Other : __________

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 TO Lexington Ob/gyn