REPRODUCTIVE GYNECOLOGY, INC.
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND/OR RELEASE OF MEDICAL CHART CONTENTS

Please release the following information from: _____
Facility or Medical Entity

to:_____ via fax: _____ or mail to:

_____
Address

_____ Entire Medical Record _____ (Pt. Must Initial) Or Circle (any or all):

Inpatient Records	Outpatient Records	Consults
Laboratory Result Records	Medical H&P Exam	Progress Notes
Pathology	Physician Orders	Mammography
Radiology	Discharge Summary	Operative Report
Psychiatric/Psychological Eval.	Medication Records	

Dates of Service: From: _____ Through: _____

_____ **DO NOT RELEASE HIV / BEHAVIORAL HEALTH DRUG AND ALCOHOL**

PLEASE ALLOW 7 – 10 BUSINESS DAYS TO PROCESS THIS REQUEST

I UNDERSTAND THE FOLLOWING: MY HEALTH RECORD(S) WILL NOT BE RELEASED OR OBTAINED BY RGI UNLESS PERMISSION IS PROVIDED FOR HEREIN AS EVIDENCED BY THE SIGNATURE ON THIS AUTHORIZATION FOR RELEASE OF PHI AND WILL BE FOR THE PURPOSE STATED ON THIS FORM AND ONLY THOSE ITEMS CHECKED OFF WILL BE RELEASED; THAT THE HEALTH RECORDS RELEASED BY RGI MAY POSSIBLY BE RE-DISCLOSED BY THE FACILITY THAT RECEIVES THE RECORDS AND THAT RGI AND ITS STAFF HAS NO RESPONSIBILITY AS A RESULT OF THE RE-DISCLOSURE AND SUCH INFORMATION WOULD NO LONGER BE PROTECTED BY THE PRIVACY RULE. THIS RELEASE IS IN EFFECT FOR A PERIOD OF 90 DAYS FROM THE DATE OF SIGNATURE AND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION WITHIN THAT 90 DAYS BY SENDING A WRITTEN REQUEST TO RGI'S HIPPA'S PRIVACY OFFICER, AT 95 ARCH STREET, STE. 250, AKRON, OHIO 44304 VIA CERTIFIED MAIL. MY DECISION TO REVOKE THIS AUTHORIZATION DOES NOT APPLY TO ANY RELEASE OF MY HEALTH RECORDS THAT MAY HAVE TAKEN PLACE PRIOR TO THE DATE OF MY REQUEST TO REVOKE AUTHORIZATION AND THAT IT MAY RESULT IN MY INSURANCE COMPANY DENYING PAYMENT FOR MEDICAL CARE THAT I WOULD THEN BE LIABLE FOR TO RGI. I AM ENTITLED TO A COPY OF THIS COMPLETED AUTHORIZATION FORM.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PATIENT PRINT NAME
or LEGAL REPRESENTATIVE_____ _____
RELATIONSHIP: _____ SOCIAL SECURITY NUMBER