OXFORD OB/GYN, INC.
5225 Morning Sun Road, Suite A
Oxford, Ohio 45056
513-523-2158
Fax: 513-523-0019

Authorization For Use/Disclosure Of Protected Health Information

Patient Information (Please Print)

NAME:
ADDRESS:
PHONE: CELL PHONE:

DOB: SSN:

PLEASE INCLUDE THE FOLLOWING RECORDS:
___All Records from ___________ to ___________
___Also include any STD Testing I have received.
___Also include any AIDS Testing I have received.
___Only include these specific records___________
____

Medical Records From:

____
____
____

Medical Records To:

____
____
____

Information May Be:
☐ Mailed
☐ Reviewed
☐ Picked Up By Whom:_____________

Purpose For Disclosure
☐ Medical Care
☐ Attorney/Legal
☐ Personal
☐ Insurance
☐ Disability/SSI
☐ Other_________________

Copy Charge: _______________needs to be paid prior to copying chart.

Oxford Ob/Gyn, Inc. will not condition treatment, payment enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that a standardized fee has been established for copies of medical records. The fee for copying of medical records needs to be paid prior to release of records.

I, the undersigned, hereby authorize Oxford Ob/Gyn, Inc. to use and/or disclose information from my medical or financial record as specified above.

Signature:_________________ Date:_________________ Patient Parent Legal Guardian
(circle one)