OB/GYN
ASSOCIATES OF ERIE

524 W. 24th Street
Ashtabula, OH 44004
(440) 997-6915
Fax: (440) 997-6976

100 Peach Street
Suite 300
Erie, PA 16507
(814) 459-1851
Fax: (814) 456-0541

2315 Myrtle Street
Suite 220
Erie, PA 16502
(814) 454-8185
Fax: (814) 454-3894

406 W. Oak Street
Titusville, PA 16354
(814) 827-7229
Fax: (814) 827-4869

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Accepted methods of transmission are via fax, paper mail, or direct message. Please do not send compact discs.

Print Patient Name Date of Birth SSN

I HEREBY AUTHORIZE:

_____
(Doctor/Group/Clinic Name)

_____
(Address)

_____
(City) (State) (ZIP)

_____
(Fax Number)

TO RELEASE INFORMATION IN MY MEDICAL RECORDS. PLEASE INCLUDE:

☐ All my medical records INCLUDING mental health/alcohol and/or drug abuse/HIV/STD.

☐ All my medical records EXCLUDING mental health/alcohol and/or drug abuse/HIV/STD.

☐ Specific records: _____ Date:_____

THESE RECORDS ARE TO BE SENT TO:

_____

_____

_____

FOR THE PURPOSE OF:

☐ Second Opinion ☐ Copy to Family Physician ☐ Insurance Purpose ☐ Relocation

☐ Transfer Care to Another Physician/Practice ☐ Other, Please Describe _____

This consent is valid for sixty (60) days from the date of my signature. I understood that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to the above authorized Doctor/Group/Clinic. I also understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. Information disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified above and is no longer protected by federal privacy regulations.

Patient Signature Date

Medical information can be sent via email to **records@obgynoferie.com** or via fax to (814) 456-0541.
It is the responsibility of the sender to encrypt sensitive information.