HIPAA AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, voluntarily authorize the disclosure of information from my heath record to be released to **OBGYN of Westlake, LLC**.

Patient name _____

Maiden name _____

Date of Birth _____

Patient address _____

Patient Phone number _____-_____-_____

FACILITY REQUESTING:

DR. RIMA BACHUWA

DR. GEORGE STOKES

29099 HEALTH CAMPUS DR. STE. 350

WESTLAKE, OH 44145

Phone: 440-871-2222 Fax: 440-249-4111

PREVIOUS PHYSICIAN INFO:

_____

_____

_____

_____

_____

INFORMATION REQUESTED:

_____

_____

REASON FOR RELEASE OF INFORMATION:

_____

_____

Patient's Signature or Representative Date

_____

Printed Name of Patient or Representative/Relationship to Patient Date

The information to be released for the purpose stated above and may not be used by recipient for any other purpose.
I understand that this Authorization is effective for a period of 180 days from the date of signature, unless otherwise specified. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information.