Lifeline Medical Associates

Transforming Women's Healthcare
www.LMA-LLC.com

Delaware Valley OBGYN & Infertility Group, PC

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By signing this form, I authorize_____to release a copy of my medical records to the facility listed below.

Patient Name:_____DOB:_____

The information you may release subject to this signed release form is as follows:
☐ Complete Records
☐ Lab/Pathology Reports
☐ History & Physical
☐ Operative Reports
☐ Progress Notes
☐ Radiology Reports

Release my protected health information to the following facility:

Delaware Valley OBGYN & Infertility Group, PC

☐ 2 Princess Road, Suite C
Lawrenceville, NJ 08648
P: (609) 896-0777
F: (609) 896-3266

☐ 300B Princeton-Hightstown Road, Suite 202
East Windsor, NJ 08520
P: (609) 896-0777
F: (609) 443-4506

_____ _____

Signature Printed Name

_____ _____

Witness Signature Witness Printed Name

_____

Date

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize ***Delaware Valley OB/GYN and Infertility Group, P.C.*** ("Covered Entity" the "Practice") to release my health information described below to:

Patient Name:_____ Date of Birth _____

Patient Address: _____

_____

Patient Telephone Number: _____

Documents/Information to Be Released:

☐ Complete Health Records ☐ Consultation Reports ☐ Radiology Reports
☐ Consultation Reports ☐ Operative Notes ☐ Laboratory Reports
☐ Radiology ☐ Other (please specify)_____

Purpose of Disclosure:

☐ At the request of the patient ($1 per page fee up to $100) ☐ Transfer to another practice (fee may apply)

I understand that the terms of this authorization are governed by the Health Insurance ·Portability and Accountability Act of 1996, and Its implementing regulations ("HIPAA'?, I understand that I have the right to revoke this authorization, at any time prior to Covered Entity's compliance with the request set forth herein, provided that the revocation Is in writing. I further understand that additional Information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth In Covered Entity's Notice of Privacy Practices. I understand that any revocation must: Include my name, address, telephone number, date of this authorization and my signature and that I should send it to:

Delaware Valley OB/GYN and Infertility Group, P.C.
2 Princess Rd., Suite C • Lawrenceville, NJ 08648 • Fax: (609) 895-0643
Attn: Medical Records

I understand that I am not required to sign this authorization and that Covered Entity may not condition treatment payment, enrollment In health plan or eligibility for benefits) on my execution of this authorization.
I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.
This authorization expires upon Covered Entity's release of the Information described above or thirty days after the date of Authorization, as set forth below, whichever comes first.

☐ Please mail my records to my provider (No charge)
Provider Name: _____
Provider Address: _____

☐ I will pick-up records (Fee applies) ☐ Mail my records to my address (Fee applies)

☐ I will authorize the individual listed below to pick-up my medical records on my behalf.
(Please Print)_____ Relationship to Patient:_____

I hereby acknowledge receipt of a copy of this Authorization.

_____ _____

Signature of Individual of Personal Representative Date

Description of Personal Representative's Authority: _____