Walter E. Boehm Birth Defects Center

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Peter E. Boehm, Sr., MD
Peter Boehm, Jr. MD
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Paul Zmaj, MD
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Patient Name_____ DOB _____

Address_____

_____

Phone_____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above named person be forwarded:

FROM: **Person/Institution** _____

Address _____

City _____ **State** _____ **Zip** _____ **Fax Number** _____

TO: **Person/Institution** _____

Address _____

City _____ **State** _____ **Zip** _____ **Fax Number** _____

Purposes / need for information _____

Disclosure will include: (check all that apply)

☐ Face Sheet	☐ History & Physical	☐ Laboratory Report	☐ Operative Report	☐ All
☐ Discharge Summary	☐ Progress/Physician Notes	☐ X-Ray/Radiology Report	☐ Pathology Report	☐ Other _____
☐ Emergency Report	☐ Nurses Notes	☐ EKG/EMG/EEG Report	☐ Consultation Report	

Records for the (dates) from _____ to _____

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This authorization shall remain valid unless revoked but **will expire one (1) year from signing**. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian/Personal Representative (Required if Patient is not legally authorized to sign Authorization) Relationship to Patient

_____

Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that the Walter E. Boehm Birth Defects Center cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information about drug and/or alcohol abuse, HIV and mental health treatment.