Susquehanna OB/GYN & Nurse Midwifery

Release of Health Information Authorization

This form is designed to adhere to federal privacy regulations of the DHHS at 42 CFR §164.508 and the Annotated Code of Maryland, Title 10 Health General Article §4-301 to §4-307.

I give Susquehanna OB/GYN permission to:

Release information about HIV/AIDS Yes or No
Release mental health records Yes or No
Release drug/alcohol treatment Yes or No
Call me at my work or cell number Yes or No
Leave a voice mail for me Yes or No
Discuss appointments with others Yes or No
Leave messages with others Yes or No

Name of person(s) _____

_____

I understand:

- This authorization is voluntary.
- My treatment, payment for it & benefits are not affected by this authorization.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization may be revoked by me at any time in writing, unless release has been made prior to receipt of revocation
- Once information has been disclosed, re-disclosure by the recipient is not covered by this authorization form.

_____
Print Name

_____
Signature

_____
Date

Notice of Privacy Practices Attestation

I acknowledge that I have read and have been offered a copy of the Notice of Privacy Practices for Susquehanna OB/GYN & Nurse Midwifery.

_____
Signature

_____
Date

Questions or complaints about the federal privacy regulations or policies and procedures relating to these federal regulations should be directed to our Privacy and Security Officer Deborah Handshoe at (410) 939-3121 ext. 39 or email at dhandshoe@sogmd.org.

The acknowledgements on this form will expire one year from the date it is signed unless a shorter time is indicated here: _____.