



200 Nash Medical Arts Mall • Rocky Mount, NC 27804
252-443-5941 or 1-800-521-5199 • www.nashobgyn.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Nash OB-GYN Associates, P.A., to transfer, release or obtain information on:

(Patient Name)

(Date of Birth)

(Social Security Number)

OBTAIN FROM

SEND OR FAX TO:

(Physician/Institution)

(Physician/Institution)

(Attention)

(Attention)

(Address)

(Address)

(City, State, Zip)

(City, State, Zip)

(Phone)

(Fax)

(Phone)

(Fax)

For the purpose of: _____

Date(s) of Treatment: All dates Specific dates: _____ thru _____

Is this a permanent transfer? Yes No

I understand that my records may contain but is not limited to: history, diagnosis, and /or treatment of HIV (AIDs virus), other sexually transmitted diseases, and / or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Authorization is valid for 90 days from the date of signature unless revoked in writing.
I have read and understand this consent and I have voluntarily signed it.**

(Signature of Patient or Parent/Legal Representative)

(Relationship to Patient)

(Date)

(Patient's Address, City, State, Zip)

(Patient's Phone)

**Please note: Copying of medical records is provided and billed by a contracted agency.
You will be invoiced directly for any applicable cost associated with copying your records.**