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:	**PREVIEWS PHYSICIAN INFO:**
DR. RIMA BACHUWA	_______________________________________
DR. GEORGE STOKES	_______________________________________
2211 CROCKER ROAD SUITE 130	_______________________________________
WESTLAKE, OH 44145	_______________________________________
Phone: 440-871-2222 Fax: 440-249-4111	_______________________________________

INFORMATION REQUESTED:

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REASON FOR RELEASE OF INFORMATION:

____

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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.