OB RELEASE OF INFORMATION

I, ____, SS# _____-____-_____, DOB _____/_____/_____,
hereby authorize and give my consent to Paragon Health Associates, L.L.C. and its respective agents and employees to release information limited to the following specific items:

(1) Office Visits
(2) Medical Information
(3) Test Results
(4) Amniocentesis
(5) Ultrasound

☐ I **do not** permit the release of confidential information to anyone other than myself.

☐ I permit the confidential information to be released only to the following person(s) for the reasons specified and effective for the time frame specified or eight (8) weeks after my pregnancy ends, whichever comes first:

Name: ________________________ Relationship to Patient: ____________________ Last 4 Digits of SS#: ______

Effective through: ☐ Entire Pregnancy or until _____/_____/_____ .

Information to be released: ☐ Any and all information ☐ Office Visits only ☐ Test Results only ☐ Ultrasounds only

☐ Amniocentesis Results only ☐ Exceptions/Other: ____

Name: ________________________ Relationship to Patient: ____________________ Last 4 Digits of SS#: ______

Effective through: ☐ Entire Pregnancy or until _____/_____/_____ .

Information to be released: ☐ Any and all information ☐ Office Visits only ☐ Test Results only ☐ Ultrasounds only

☐ Amniocentesis Results only ☐ Exceptions/Other: ____

Name: ________________________ Relationship to Patient: ____________________ Last 4 Digits of SS#: ______

Effective through: ☐ Entire Pregnancy or until _____/_____/_____ .

Information to be released: ☐ Any and all information ☐ Office Visits only ☐ Test Results only ☐ Ultrasounds only

☐ Amniocentesis Results only ☐ Exceptions/Other: ____

This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken. It shall be effective from the date of signing until eight (8) weeks after my pregnancy ends or until the following date: ____________________. No further confidential information will be released without the execution of an additional written statement of consent. I understand that I am not required to give this consent and that I can refuse without any prejudice to my future medical treatment or care.

_____/_____/_____
Date of Consent

____
Signature of Patient

Paragon Health Associates, LLC abides by the HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations set forth by the Department of Health and Human Services. All policies and procedures are in accordance with privacy and compliance regulations. This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

Paragon Health Associates, LLC 1 Park West Blvd, Suite 200, Akron, Ohio 44320 Phone: 330.869.9777 Fax: 330.869.0052

GYN RELEASE OF INFORMATION

I, ____, SS# _____-____-______, DOB _____/_____/_____,

hereby authorize and give my consent to Paragon Health Associates, L.L.C. and its respective agents and employees to release information limited to the following specific items:

(1) Office Visits
(2) Medical Information
(3) Test Results
(4) Ultrasound
(5) Bone Densitometry/DEXA Scan

☐ I DO NOT permit the release of confidential information to anyone other than myself.

I permit the confidential information to be released **only** to the following person(s):

Name: ____ **Last 4 Digits of SS#:** _________

Information to be released: ☐ Any and all information ☐ Office Visits only ☐ Test Results only

☐ Ultrasounds only ☐ Bone Densitometry/DEXA scan only ☐ Exceptions/Other: ____________________

____

Name: ____ **Last 4 Digits of SS#:** _________

Information to be released: ☐ Any and all medical information ☐ Office Visits only ☐ Test Results only

☐ Ultrasounds only ☐ Bone Densitometry/DEXA scan only ☐ Exceptions/Other: ____________________

____

Name: ____ **Last 4 Digits of SS#:** _________

Information to be released: ☐ Any and all medical information ☐ Office Visits only ☐ Test Results only

☐ Ultrasounds only ☐ Bone Densitometry/DEXA scan only ☐ Exceptions/Other: ____________________

____

This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken. It shall be effective for one (1) year from the date of signing or until the following date (not to exceed one year): ____________________. No further confidential information will be released without the execution of an additional written statement of consent. I understand that I am not required to give this consent and that I can refuse without any prejudice to my future medical treatment or care.

_____/_____/_____ ____

Date of Consent Signature of Patient

Paragon Health Associates, LLC abides by the HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations set forth by the Department of Health and Human Services. All policies and procedures are in accordance with privacy and compliance regulations. This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.