



North Oaks

Obstetrics & Gynecology

WILLIAM G. BLACK, M.D.
WILLIAM F. BEACHAM, M.D.
DWAN S. MABRY, M.D.
GARY AGENA, M.D.
BRIAN G. ASHFORD, M.D.

BOARD CERTIFIED FELLOWS OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

HIPPA Compliant Medical Authorization

Request date: _____

Patient _____ Previous name _____

DOB _____ SS# _____ Phone# _____

This authorization expires on the 30th day from the date of signature.

Authorization for _____ to disclose my health care information.
(The facility or custodian/keeper of your records)

Address _____ State _____ Zip _____

You may use or disclose the following health care information:

Dates of service from _____ to _____. () Progress Notes, () H & P, () Consultations reports
() Radiology, () Aid (acquired immunodeficiency Syndrome) or HIV information, () Laboratory,
() Entire Chart- excluding billing information OR () Other _____

You may use or disclose this information to:

Name (or title) and organization _____

Address _____ City _____ State _____ Zip _____

Phone# _____ Fax# _____

Purpose of this authorization:

{ } At my request { } Continuing Care { } Insurance { } Legal, { } Other _____

() Check here only when North Oaks OB-Gyn requests the authorization for marketing purposes.

() Check here only when North Oaks OB-Gyn will get something of value for providing health information for marketing purposes.

Delivery method { } Mail { } Patient / Authorized Legal Representative will pick up. { } Fax _____

My Rights

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility). However I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party or to take part in a research study.
- I may revoke this authorization in writing by sending a letter to the health care provider to whom he authorization is directed. If I did, it would not affect any actions already taken by the health care provider based upon this authorization.
- I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that once the health care provider discloses my health information, the person or entity that receives it may re-disclose it. The HIPPA Privacy laws may no longer protect it.
- I also realize that I am responsible for fees incurred by the copying of my medical record. Our current fees are as follows: \$7.50 processing fee and \$1.00 for each page up to 25 pages then the fee reduces to \$.50 per page there after. I understand that I will be provided with a Concise charge for these services and that these fees will need to be paid for before my medical records are released.
- North Oaks OB-Gyn, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein.

Patient signature: _____ Date: _____

Individual legally authorized to sign on behalf of the patient

Representative's authority to act for patient

MAIN OFFICE

15748 Medical Arts Plaza
P.O. Box 1908 • Hammond, LA 70404
Ph. 985-542-0663 • FAX 985-542-0698