Authorization for Release of Medical Records

Patient Name: ____ DOB: ____________

Address: ____

This is my written authorization to *OBTAIN* information from:

Office/Provider Name: ____

Provider Address: ____

Provider Phone: ______________________________ Fax______________________

This is my written authorization to *RELEASE* information to:

Office/Provider Name: ____

Provider Address: ____

Provider Phone: ______________________________ Fax______________________

Information to be released:

( ) All Medical Records ( ) X-ray, Ultrasound, Imaging Results ( ) Physician Notes

( ) Lab Results ( ) Hospital records

I understand that these records may include information on STD's, AIDS, HIV, mental health and drug or alcohol abuse.

( )YES, I authorize release of this information **( ) NO**, I do not authorize release of this information.

I understand this authorization may be revoked in writing a any time.

The providers and its staff of PrimeGyn Women's Center are released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian: ___________________________________ Date: ______________