Alliance
Obstetrics & Gynecology

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Authorization for Release of Medical Records

_____ _____
Patient's full name Birth date (month/day/year)

_____ _____
Street address SS#

_____ _____
City, state, zip code Phone number

I hereby authorize the following to release my medical records to *Alliance Obstetrics & Gynecology Group, LLC:*

_____ _____
Name of company Street address

_____ _____
Phone number City, state, zip code

Dates: ☐ all ☐ limited to _____

Records: ☐ all ☐ limited to:

History & Physical	Laboratory Reports
Progress Notes	Pathology Reports
Operative Notes	Radiology Reports
Discharge Summary	ECG/EEG Reports
Emergency Report	Other _____

I do/ I do not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I hereby authorize disclosure of the health information as listed above. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request at anytime, in writing, but this cancelation will not apply to previously released information. I understand that any released information is subject to re-disclosure by the recipient.

_____ _____
Printed Name/Responsible Party Date

_____
Signature of Patient/Responsible Part