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PRACTICE LIMITED TO OBSTETRICS & GYNECOLOGY

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ - _____ - _____ Maiden Name: _____

Other Names Used: _____

I HEREBY authorize medical information regarding the above identified person to be released

From: _____

AND SEND TO: _____

Approximate Date of Care: _____

Records Requested: _____

PATIENT MUST INITIAL EACH BOX TO BE VALID

Alcohol

HIV Tests

Drug Abuse Records

Psychiatric / Mental Health Records

AIDS Diagnosis

Other _____

I hereby consent to the release of the above information obtained in the course of my diagnosis and treatment. This authorization is valid for six (6) months unless previously revoked in writing. Any redisclosure of information obtained by this authorization is prohibited.

Print Name: _____

Signature: _____ **Date:** _____

Witnessed By: _____ **Date:** _____