ASSOCIATES IN OBSTETRICS & Gynecology

Authorization to Release Medical Records*

I, _____ , _____ /_____ /_____
(PATIENT NAME) (DATE OF BIRTH)

authorize the health care provider to release the information specified below to the organization, agency or individual named on this request.

Initial all that apply:

_____ Standard Records (Last Five Years)
_____ All Records (Not including records from other physicians)
_____ Specific Services: _____
_____ Specific Services: _____

**The patient has the right to revoke permission in writing at any time. However, we cannot take back any disclosures we have already made.

OB/GYN records may include AIDS/HIV, STD, psychiatric, and substance abuse information. Please specify if you **DO NOT want any or part of these records to be included.

_____

_____

_____ PLEASE INITIAL THAT YOU UNDERSTAND THE ABOVE.

Records released from:

_____
(FACILITY OR DOCTOR'S NAME)

_____
(MAILING ADDRESS)

_____
(CITY, STATE AND ZIP)

PHONE: _____
FAX: _____

_____
(SIGNATURE)

Send to:

_____
(FACILITY OR DOCTOR'S NAME)

_____
(MAILING ADDRESS)

_____
(CITY, STATE AND ZIP)

PHONE: _____
FAX: _____

_____
(DATE**)

*We reserve the right to charge a fee for copying.
**This release will automatically expire one year from the date signed.