AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records coming from: Name: ____
Address: ____
City: ________________________State: _______ Zip: __________
Phone: ________________________ Fax: _____________________

Records going to: Name: ____
Address: ____
City: ________________________State: _______ Zip: __________
Phone: ________________________ Fax: _____________________
______Mail ______Fax _____Pick Up

I authorize the release of records, including those that may contain confidential HIV/AIDS related information, confidential communicable disease related information, and information relating to mental health and/or alcohol/drug use. Please release the following records:

_______Prenatal/Obstetrical Records Date of Service __________

_______Lab Report Date of Service __________

_______Operative/Pathology Report Date of Service __________

_______Gynecological Record Date of Service __________

_______Other (please specify) ______________ Date of Service __________

_______Complete Record

Reason for request ____

Patient Name ____

Date of Birth ____________________ Social Security Number___________________

____ ____________________
Signature of Patient **Date**

Signature of Other Authorized Person ____

Print Name ___________________________ Relationship of Patient_______________

Witness ________________________________

****This consent shall expire automatically six (6) months from the date on which it was signed.***

___I understand there is a $35 fee for copies of medical records for personal use. (please initial)