Authorization to Release Medical Information

Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

Patient_____ Birthdate _____

Contact #_____

I consent to the release of Medical Information (records):

To (Physician, Clinic or Person)	From (Physician Clinic or Person)
Name_____	Name_____
Address_____	Address_____
Phone #_____	Phone #_____
Fax #_____	Fax #_____

Information to be Released:

***Please initial if release is authorized**

_____ History

_____ Operative/report/type operation

_____ X-rays: Type_____

_____ Lab, Pathology reports

_____ Other tests and studies (list type of test/study and date performed)

_____

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record:

***Please initial if release is authorized**

_____ Drug and alcohol abuse

_____ Information related to diagnosis/treatment of HIV

**Please note that a separate release is required for Behavioral Health Information*

Purpose of Disclosure:

_____

_____

This authorization is **valid for six months** after the date of signature. The authorization may be revoked at any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

_____ _____

Signature of Patient or Legally Authorized Representative | Date

BEVERLY FULLER, MD, FACOG
independent physician and surgeon

JULIE KING, MD, FACOG
independent physician and surgeon

DANIEL A. TOMLINSON, MD, FACOG
independent physician and surgeon

CARISSA M. ROSS, MD
independent physician and surgeon

MARY STRIZZI, DO
independent physician and surgeon

KIMBERLY D. LARSON, WHCNP, RN, MSN
nurse practitioner

KATHRYN STRINGER, FNP, CNM
nurse practitioner

ELIZABETH PETHTEL, FNP
nurse practitioner

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