

Authorization to Release Medical Information



Patient _____ Birthdate _____

Contact # _____

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

To (Physician, Clinic or Person)

Name _____

Address _____

Phone # _____

Fax # _____

From (Physician Clinic or Person)

Name _____

Address _____

Phone # _____

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

JULIE KING, MD, FACOG
independent physician and surgeon

CARISSA M. ROSS, MD, FACOG
independent physician and surgeon

MARY STRIZZI, DO, FACOG
independent physician and surgeon

JONATHAN FREEMAN, MD, FACOG
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EMILY STEINBIS, MD, FACOG
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nurse practitioner

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nurse practitioner

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