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
City, State, Zip	City, State, Zip
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

JULIE KING, MD, FACOG
independent physician and surgeon

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

MARY STRIZZI, DO, FACOOG
independent physician and surgeon

JONATHAN FREEMAN, MD, FACOG
independent physician and surgeon

EMILY STEINBIS, MD, FACOG
independent physician and surgeon

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

KENDALL OLSON-CASSIDY, CNM
nurse practitioner

LORETTA SANDOVAL, CNM, NP
nurse practitioner

KATHRYN STRINGER, FNP, CNM
nurse practitioner

ELIZABETH PETHTEL, FNP
nurse practitioner

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