ADVANCED OBSTETRICS & GYNECOLOGY

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AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Patient name: _____ DOB: _____/____/____
Did you use any other name? (Please provide) _____

OBTAIN FROM: (Releasing facility)
NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

RELEASE TO: (Receiving entity)
NAME: _____

Providers' name: _____

ADDRESS: _____ CITY: _____STATE: _____ZIP: _____

PHONE: _____ FAX: _____
I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by Advanced Obstetrics & Gynecology. I understand that this authorization is voluntary; that further treatment cannot be conditioned upon my signing this authorization and that there may be a fee for records.

INFORMATION TO BE RELEASED (check all that apply):

____ Clinic Notes Dates: From: _____- To: _____ ____ Labs

____ Operative Notes ____ Radiology Reports

____ other test results: _____

____ All records generated at this office

***** We can only release OUR records. We cannot forward records that we have received from any other physician or practice to include emergency room or urgent care notes. You will need to obtain those records directly from the rendering physician or facility who provided your care. *****
AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked.

Signature of Patient: _____ DATE: ____/____ /_____