3lessings OB GYN & Women's health care

Authorization for Release of Medical Records

Patient Name: _____

Address: _____

DOB: ____/____/____ Social Security Number: _____

This is my written authorization to OBTAIN/ RELEASE information TO/FROM:

Office/ Provider name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax: _____

Release Format: ( ) Mail ( ) To Fax ( ) to be Picked up on: _____

Information to be released:

( ) All Medical Records	( ) Lab Reports	( ) Physicians Notes
( ) Prenatal Records	( ) X-Ray/ Ultrasound	( ) Hospital
( ) Demographics	( ) Insurance Card	( ) Other: _____

I understand that these records may include information on sexually transmitted diseases, AIDS, HIV, mental, health, alcohol/ drug abuse.

( ) **YES**, I authorize the release of this information. ( ) **NO**, I do not authorize the release of this information. REVOCATION: I understand this authorization may be revoked in writing at any time. Unless otherwise indicated this authorization will expire 90 days from the date of signature. The physician and employees are released from any legal responsibility for disclosure of the above information to the extent indicated an authorized herein.

I have read the above and authorized the disclosure of the protected health information as stated.

Signature of Patient/Guardian: _____ Date:_____

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