MYRTLE STREET
Obstetrics & Gynecology, P.C.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____ Date _____

Address _____

Phone _____ Date of Birth _____

Records Requested From _____
DOCTOR OR HOSPITAL

_____
ADDRESS

I hereby authorize and request you to release medical information from my medical record <u>to</u>:

Name of Doctor, Hospital, etc. _____

Address _____

This release is limited to:

_____ Entire record including HIV information _____ Records from previous physicians

_____ Complete prenatal record including HIV information

_____ Specific Information (lab reports, operative reports, etc.) _____

_____ Exclusions _____

Reason for request _____

This authorization to release confidential information may be revoked in writing by me at any time, except to the extent that action has already been taken. It shall be effective until _____, and no further confidential information will be released without the execution of an additional written statement of consent.

SIGNATURE _____ WITNESS _____
IF NOT PATIENT, STATE RELATIONSHIP

DATE _____

I give special permission to release any information regarding: (Initial on line below that you grant us permission to release the information to the above.)

_____ Substance Abuse _____ Psychiatric/Mental Health Information

Reason for release of this information _____

SIGNATURE _____ WITNESS _____
IF NOT PATIENT, STATE RELATIONSHIP

DATE _____ TIME _____