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Authorization to Release Medical Records*

I, _____, _____ / _____ / _____ - _____ - _____
(PATIENT NAME) (DATE OF BIRTH) (SSN)

authorize the health care provider to release the information specified below to the organization, agency or individual named on this request.

Initial all that apply:

- _____ Standard Records (Last Five Years)
- _____ All Records (Not including records from other physicians)
- _____ Previous Physicians Records
- _____ Specific Services

** The patient has the right to revoke permission in writing at any time. However, we cannot take back any disclosures we have already made.

** OB/GYN records may include AIDS/HIV, STD, psychiatric, and substance abuse information. Please specify if you **DO NOT** want any or part of these records to be included.

_____ PLEASE INITIAL THAT YOU UNDERSTAND THE ABOVE.

Records released from:

Send to:

(FACILITY OR DOCTOR'S NAME)

(FACILITY OR DOCTOR'S NAME)

(MAILING ADDRESS)

(MAILING ADDRESS)

(CITY, STATE AND ZIP)

(CITY, STATE AND ZIP)

PHONE: _____

PHONE: _____

FAX: _____

FAX: _____

(SIGNATURE)

(DATE**)

*We reserve the right to charge a fee for copying.

**This release will automatically expire one year from the date signed.