

OB&GYN CENTER
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print patient's full name

Birth date (Mo/Day/Yr)

Street address

Social security number

City, state, zip code

Phone #

I do hereby authorize you to release my records:

Name of Company/Agency/Facility/Person

Street address

City, state, zip

Dates of _____

| | | |
|--------------------------|---------------------------|-------------------------|
| _____ DISCHARGE SUMMARY | _____ PATHOLOGY REPORTS | _____ EMERGENCY REPORTS |
| _____ HISTORY & PHYSICAL | _____ LABORATORY REPORTS | _____ ALL RECORDS |
| _____ PROGRESS NOTES | _____ RADIOLOGY REPORTS | _____ OTHER _____ |
| _____ OPERATIVE NOTES | _____ ECG/EEG/CARDIC CATH | _____ |

_____ I do _____ I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Mail to: OB&GYN Center, 97 Thomas Johnson Drive, Ste 101, Frederick, MD 21702

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or Personal Representative of patient's estate

Date