

**OB&GYN CENTER**  
**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
(Print patients full name)

\_\_\_\_\_  
Birth date (Mo/Day/Yr)

\_\_\_\_\_  
(Street address)

\_\_\_\_\_  
Social security number

\_\_\_\_\_  
(City, state, zip code)

\_\_\_\_\_  
Phone #

At the request of the individual, I \_\_\_\_\_, do hereby authorize **OB&GYN Center** to release:  
(Patients Name)

DATES OF \_\_\_\_\_

\_\_\_\_\_  
DISCHARGE SUMMARY  
\_\_\_\_\_  
HISTORY & PHYSICAL  
\_\_\_\_\_  
PROGRESS NOTES  
\_\_\_\_\_  
OPERATIVE NOTES

\_\_\_\_\_  
PATHOLOGY REPORTS  
\_\_\_\_\_  
LABORATORY REPORTS  
\_\_\_\_\_  
RADIOLOGY REPORTS  
\_\_\_\_\_  
ECG/EEG/CARDIC CATH

\_\_\_\_\_  
EMERGENCY REPORTS  
\_\_\_\_\_  
ALL RECORDS  
\_\_\_\_\_  
OTHER  
\_\_\_\_\_

\_\_\_\_\_ 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.

\_\_\_\_\_ I will not be returning to the practice so please put me in the inactive file status.

**INFORMATION RELEASE TO:**

\_\_\_\_\_  
Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City, state, zip

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Fax #

**Please provide current telephone number in the event we need to contact you:** \_\_\_\_\_

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 authorization 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**

*NOTE: Maryland State Law permits a fee to be charged for copying/transferring of records. This facility will invoice you directly according to applicable rates by Maryland State Law. Pre-payment is required prior to release of records.*