North Springs Ob|Gyn

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Phone #:_____
Social Security Last 4 #: _____ DOB: _____

Licensed Provider/Office to receive records: _____
Complete Address: _____
Office Phone: _____ Fax: _____

Licensed Provider/Office to provide records: _____
Complete Address: _____
Office Phone: _____ Fax: _____

Reason for records request: _____

_____

I authorize the above health care provider to release the information specified below to the licensed provider, or individual name (self) on this request.

_____ All medical records generated at this facility.
_____ All records pertaining to current pregnancy with EDD: _____
_____ A portion of medical records generated by this facility (Specify below):
_____
_____ Drug and/or Substance Abuse, If any
_____ AIDS/HIV, If any
_____ Psychological or Psychiatric conditions, If any

_____

I understand that I may revoke this authorization at any time.
A copy of this authorization may be utilized with the same effectiveness as an original.

Print Name: _____

Patient's Signature: _____

Authorized Signature/Relationship to Patient: _____

Date: _____