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AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician or Facility to provide records: _____
_____
_____
Patient's Name: _____
Social Security # _____ DOB: _____
Person or Provider to receive records: **North Springs Ob/Gyn**

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

_____ **ALL** medical records at this facility
_____ **ONLY** the medical records generated by this facility
_____ 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 or Authorized Signature: _____

Relationship to patient: _____

Date: _____