CROWN
Obstetrics and Gynecology

Authorization to Release Medical Information

Patient Name _____ Date of Birth _____ MR# _____

Maiden or Previous Name _____

Patient Address _____

I authorize _____ Address_____ (T) _____

To release to: _____Address_____ (T) _____

For the purpose of _____

Specific Information Requested:

All Records _____	Lab Reports _____
History & Physical _____	X-Ray Reports _____
Operative Report _____	Ultrasound Reports _____
Pathology Report _____	Discharge Summary _____

Other (please specify) _____

*** **Patient/Guardian Signature** _____ **Date** _____

Release of sensitive information: I understand that if my medical record contains information in reference to drug and/or alcohol abuse, genetic, psychiatric, venereal disease, social service, Hepatitis B testing/treatment and/or sensitive information. I agree to its release.

*** **Patient/Guardian Signature** _____ **Date** _____

Release of HIV information: In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records release, you must sign and date on the line below.

*** **Patient/Guardian Signature** _____ **Date** _____

There is a 7 business day waiting period for the release of the requested information.

You have the right to revoke this authorization, provided that such revocation is in writing.

Information disclosed pursuant to this authorization may be subject to further disclosure by the recipient and may no longer be protected by the federal privacy rule.

This authorization is valid for two years.

This is a 25-cent per page charge for medical records not to exceed $20.00

Are you leaving the practice? YES or NO Reason _____

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