Generations OB/GYN Group, P.A.

OBSTETRICS AND GYNECOLOGY
DIPLOMATE, AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize and request:

_____
Name of Facility / Physician

_____
Address of Facility

and its authorized agents and employees to release the following information from the health records of:

_____ _____
Patient Name Date of Birth

_____ _____
Social Security Number Treatment Dates

The information is to released to:

_____
Name of Person or organization

_____
Address

Please release the medical records in your possession, including history, examinations, x-rays, laboratory and pathology reports concerning my care.

COMMENTS:

_____

I hereby DO/DO NOT authorize the release of any information regarding AIDS (HIV) testing: _____ (Initials)

I hereby DO/DO NOT authorize the release of any information regarding my mental health. _____ (Initials)

SIGNATURE: _____ _____
Please Print Name

Date: _____

_____
Physicians Signature

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