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Obstetrics & Gynecology
Women's Health
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I _____authorize the release of my

Medical records to:_____

From:_____

The information to be released should include:

( ) Office visits
( ) Operation reports
( ) Pathology reports.
( ) Lab results
( ) Complete medication records to exclude nothing.

The purpose for obtaining these medical records is to facilitate treatment.

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and if not revoked sooner in writing, this consent will expire **ONE YEAR** from the date below or _____, at my election.

_____

Patient's Signature Date of Birth

_____

Maiden Name Date

_____

Witness (By other than a Family Member) Date

Internal protection information.

We restrict assess of medical and personal information about you to those employees who need to know that information to provide services you require. We maintain physical, electronic, and procedural safeguards to comply with federal regulations to guard this information.