PREMIER
OBSTETRICS & GYNECOLOGY

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Authorization to Release Healthcare Information

Patient Name:_____ DOB:_____

SSN:_____ Previous Name:_____

I request and Authorize:_____
(Name of Clinic/Practice/Physician)

To release the medical records of the person named above to:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

This request and authorization applies to:

____ All healthcare information

____ Other:_____

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus,) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.

Signature:_____ Date:_____

_____
Relationship if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)