AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ________________________________ Birthdate: ______________________________

Social Security #: ___________________________ Other Name Used: __________________________

Address: ________________________________ City, State, Zip: _____________________________

Dates of Services: _________________________ Purpose of Request: _________________________

I authorize the release of the following records, including those which may obtain confidential communicable disease related information. We cannot condition our provision of services to you or receipt of this authorization. You may refuse to sign this authorization.

☐ History & Physical

☐ Discharge Summary

☐ Operative Report

☐ Pathology Report

☐ Laboratory Reports

☐ EKG Reports

☐ C-Section Operative Report

☐ X-Ray / Ultrasound

I HEREBY AUTHORIZE PREMIERE PERINATAL ASSOCIATES TO RELEASE MY RECORDS TO:

____

(Physicians, Healthcare Facility)

____

(Address)

____

(City, State, Zip Code)

____

(Telephone) (Fax)

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This authorization and request is fully understood by me. I also understand that the information used on disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer protected under federal law.

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SIGNATURE OF PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE

_________________________________ _________________________________

(RELATIONSHIP TO PATIENT) DATE