KENNESAW
GYNECOLOGY

Authorization to Release Medical Records/Information

Patient's Name _____ Date of Birth _____ SSN _____

Address _____ Phone Number _____

Medical Office/Physician to *provide* records _____ Phone/Fax # _____

Person/Facility to *receive* records _____ Phone/Fax # _____

RECORDS TO BE RELEASED

☐ All Records ☐ Annual/Physical Exam ☐ Pap Smears ☐ Mammography Reports ☐ Prenatal Records

☐ Operative Reports ☐ Pathology Reports ☐ Lab Results ☐ Biopsy Reports ☐ Ultrasound Reports

☐ Other (specify) _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

(ONLY check if you do NOT want the following information sent)

☐ Substance abuse, if any

☐ AIDS/HIV, if any

☐ Psychological or psychiatric conditions, if any

☐ Other (please specify) _____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.
Use of copies – a copy of this authorization may be utilized with the same effectiveness as an original.

Patient's Name (print) _____

Person authorized to sign for patient

_____ _____
Patient's Signature Date

_____
Print or type Name Relationship to Patient

_____
Witness Signature

_____ _____
Signature Date