

CONSENT FOR MEDICAL INFORMATION RELEASE

Name: _____ Birthdate: _____

Address: _____ SSN: _____

Home Phone: _____ Work Phone: _____

Please send a copy of my records from ATRIUM OB/GYN, INC. to:

Name: _____

Address: _____

Mail Fax To: _____ Will Pick Up

Medical records may contain previous doctor records, hospital records and/or information regarding Sexually Transmitted Infections (STI's) including HIV/AIDS; alcohol and/or other drug use; or physical abuse. For that reason, please be specific about the information you wish to have released.

_____ Entire medical record including, alcohol, drug, STI or abuse that may be contained in it.

From: _____ To: _____
(date) (date)

_____ I do NOT wish to have my entire medical record released.

Release only the following: _____

(type of information).

From: _____ To: _____
(date) (date)

Purpose of request or need for information: Continuation of Care _____ Personal _____ Other _____

Authorization will expire 60 days from date of signature.

NOTE: You may withdraw permission for the release of information at any time prior to the expiration date providing written notice to Atrium.

Information released by Atrium prior to a patient's withdrawal of consent cannot be retrieved, and Atrium will not be held responsible for such.

I hereby request Atrium to release my records as I have instructed above, and release Atrium from all legal responsibility that may arise from this act. I understand that I will be responsible for any charges incurred for copying and/or sending my medical records as permitted by law.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____