ADVANCED OBSTETRICS & GYNECOLOGY

250 Chateau Drive, Suite 100
Huntsville, AL 35801
Fax (256) 880-3838

Authorization to Release Information

Patient's Name:_____ Date of Birth: _____/_____/_____

Patient's Address: _____

_____

Release of Information from Advanced Obstetrics & Gynecology

____(Initial) I authorize Advanced Obstetrics & Gynecology to release copies of my medical records. The information should be sent to:

TO:_____(Name of Physician, Institution, Self)

_____(Address)

_____(City, State, Zip)

_____(Phone Number, Fax Number)

Release of Information to Advanced Obstetrics & Gynecology

____(initial) I authorize the release of information and medical records.

FROM:_____(Name of Physician, Institution, Self)

_____(Address)

_____(City, State, Zip)

_____(Phone Number, Fax Number

The information should be sent to:

Advanced Obstetrics & Gynecology
250 Chateau Drive, Ste 100
Huntsville, AL 35801
Fax:256-880-3838

Patient's Signature:_____ Date:_____