Advanced ObGyn
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AUTHORIZATION to RELEASE INFORMATION

Patient's Name: _____ Date: _____

Patient's Address: _____ DOB: _____

_____

Request to release my information **FROM** Advanced Obstetrics & Gynecology:

_____ I authorize Advanced Obstetrics & Gynecology to release copies of my medical records to:
(Initials)

Name of Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

Request to release my information **TO** Advanced Obstetrics & Gynecology:

_____ I authorize the release of information and medical records:
(Initials)

Name of Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

Patient's Printed Name: _____ Patient's Signature: _____

Date: _____