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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Physician: ____________________
Address: ____
Street City State Zip
Birth Date: ______________ Social Security #: ______________ Phone #: ______________

Maiden Name: ______________________ Medical Record #: ______________________

I hereby request and authorize the following institution to release my information:

Name: ______________________ Phone#: ____________ Fax #: ____________

Address: ____
Street City State Zip

Release To:

Name: ______________________ Phone #: ____________ Fax #: ____________

Address: ____
Street City State Zip

What Information to Send:

_____ A complete copy of the above named patient's Medical Records, Including all records related to Mental Health, Drug or Alcohol Condition, sexually transmitted disease or HIV status.

_____ Specific, send only: ______________________________

_____ Mammogram Films. I understand that these films are part of my Permanent record and must be returned 30 days from receipt.

Reason for Transfer of Records: ______________________________

I understand that this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. I understand that consent will expire in 60 days. Southside OB/GYN, its employees, and contracting physicians are released from liability for the release of the above information to the extent indicated and authorized herein. I understand that there may be a charge for copying of these records and/or films. A photocopy or facsimile of this authorization shall be as valid as the original.

______________________________ ______________________________
Patient's Signature Date **Witness Signature** Date

By signing this consent, I affirm that I am 18 years of age or older. If I am under 18 years, my parent or legal guardian gives consent for transfer of records, in this case, this person attests that they are, in fact, the legal representative of the minor.

______________________________ ______________________________
Parent/Guardian Signature Date Date Received by Medical Records

______________ ______________
Date Records Sent By: