SOUTHEAST OB/GYN
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CONSENT TO RELEASE MEDICAL INFORMATION

I authorize Southeast OB/GYN to obtain/release information regarding:

PATIENT NAME: _____ DOB: _____
ADDRESS: _____

_____ _____
Patient Signature Today's Date

( ) All medical records: **DO** release **HIV/AIDS** and /or sexually transmitted disease-related and/or psychological treatment and/or drug/alcohol abuse treatment information, if applicable. I understand that this is a dual release inclusive of sensitive medical information, including HIV.

( ) All medical records **with exception** of: _____
_____

( ) Send/obtain **only the following** information: _____
_____

( ) I am **transferring care** to this physician/facility: _____
_____
Reason for transferring care is ( ) MOVING ( ) INSURANCE CHANGE ( ) OTHER, please specify: _____
_____
_____

I authorize Southeast OB/GYN to OBTAIN/RELEASE information from/to the following:

Physician Name: _____ Phone: _____
Address: _____
_____
Fax number to obtain/send records: _____

I understand that my consent to release or obtain information will expire one year from the date of signature. I also understand that I may withdraw this consent at any time in writing.

For permanent records transfer, there is a fee of $.75 per page for copying and administrative costs. The fee will not exceed $20.00.

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or otherwise permitted by law. Any unauthorized disclosure is in violation of state law and may result in a fine, jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further discolsure.