SOUTHEAST OBSTETRICS & GYNECOLOGY P.C.

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CONSENT TO RELEASE MEDICAL INFORMATION

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

PATIENT'S NAME:_____ DOB:_____

ADDRESS:_____

_____ _____

Patient's Signature Today's Date

- O All medical records: DO release HIV/AIDs and/or sexually transmitted disease related and/or psychological treatment and/or alcohol abuse treatment information, if applicable. I understand this is a dual release inclusive of sensitive medical information.

- O All medical records with exception of:_____

_____

- O Send/obtain only the following information: _____

_____

- O I am transferring care to this physician/facility:_____

_____

Reason for transfer care is: O MOVING O Insurance change O Other

Please specify if other: _____

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

Physician Name:_____ Phone:_____

Address: _____

_____

Fax Number: _____

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.

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosures 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 legal action. A general authorization for the release of medical information is not sufficient for further disclosure.