

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

Patient Phone #: _____

I request and authorize Valley OBGYN Medical Group Inc. to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

The medical information/records will be used for the following purpose: _____

This request and authorization applies to:

- All healthcare information
- Healthcare information relating to the following treatment, condition, or dates:

- Other: _____

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

There will be a \$25.00 charge for all records released.

Signature: _____
Patient/Legal Representative

Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.