JASMINE WOMEN'S CENTER
OBSTETRICS & GYNECOLOGY

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, D.O.B _____, authorize and request the release of information from the healthcare facility below:
Name _____ Address _____ Contact #_____

The specific information for the following dates of service: ____/____/____ to ____/____/____

INFORMATION TO BE RELEASED (check the appropriate boxes and include other information where indicated):

___ Summary Health Information
(Includes Discharge summary, History and Physical, Radiology, Pathology, Laboratory, and Dictated notes)

___ History and Physical (e.g., Doctor Visit)
___ Discharge Summary
___ Operative Reports
___ Cardiology Records (Stress Test, EKG Test)
___ Comprehensive record
___ Laboratory Reports
___ Radiology Reports
___ Emergency Department Reports
___ Respiratory Care Records
___ Patient Discharge Instructions
___ Other: _____
_____

Information contained in the Patient's medical record related to psychiatric and/or psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date. *Initial and Date*_____

Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse. *Initial and Date*_____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). I agree to such release. *Initial and Date*_____

THE INFORMATION TO BE RELEASED WILL BE USED FOR HEALTH CARE TREATMENT/CONTINUING MEDICAL CARE/PAYMENT OR HEALTH CARE OPERATIONS

This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the address specified above (See "Specify Address" Section above). Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.

I understand authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event: _____.
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____	_____	_____
Date	Signature of Patient or Legal Representative	Signature of Witness

If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-Patient's behalf.
By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.