County Obstetrics & Gynecology, Inc.

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Authorization to Obtain or Release Confidential Information

I Authorize and Request: ______________________________

____

To Release to: ______________________________

____

The following information contained in my medical record:

___Health & Physical ___Operative Reports

___Consultation ___Pathology Reports

___X-ray Reports ___Labs/Paps _____ other

Unless you sign here, NO information about alcohol/substance abuse, HIV/AIDS, or mental health will be disclosed. _____Yes _____NO DO NOT DISCLOSE INFO

Patient Name ______________________________ Date of Birth ______________

Purpose of disclosure:______________________________

I understand that I have the right to revoke this authorization at any time. I understand if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires in 90 days and is subject to revocation at any time except to the extent that action has already been taken in reliance thereon.

______________________________ ______________________________

Patient's/Legal Guardian Signature **Date**