



**BLOOM**  
OB/GYN

**AUTHORIZATION TO RELEASE MY MEDICAL INFORMATION**

\_\_\_\_\_  
PATIENT FULL NAME

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
CITY / STATE / ZIP

(\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
PHONE (HOME /CELL)

I, \_\_\_\_\_, DO HEREBY AUTHORIZE  
BLOOM OB/GYN, LLC TO RELEASE:

- \_\_\_\_ ALL RECORDS
- \_\_\_\_ PAP SMEARS
- \_\_\_\_ PATHOLOGY REPORTS
- \_\_\_\_ LABORATORY REPORTS
- \_\_\_\_ PROGRESS NOTES
- \_\_\_\_ OPERATIVE NOTES
- \_\_\_\_ PRENATAL RECORDS INCLUDING MY PRENATAL FLOWSHEET AND PRENATAL LAB FLOWSHEET
- \_\_\_\_ OTHER: \_\_\_\_\_

PLEASE RELEASE INFORMATION TO:

PRACTICE NAME: \_\_\_\_\_

FAX: \_\_\_\_\_

PHONE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY / STATE / ZIP: \_\_\_\_\_

I HEREBY AUTHORIZE DISCLOSURE OF THE HEALTH INFORMATION FOR THE ABOVE NAMED PATIENT. THIS AUTHORIZATION IS VALID FOR 12 MONTHS FROM THE DATE OF SIGNATURE. I UNDERSTAND THAT I MAY CANCEL THIS REQUEST WITH WRITTEN NOTIFICATION BUT THAT IT WILL NOT AFFECT ANY INFORMATION RELEASED PRIOR TO NOTIFICATION OF CANCELLATION. I UNDERSTAND THAT THE MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION HIS/HER TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

\_\_\_\_\_  
DATE OF SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT