BLOOM OB/GYN

AUTHORIZATION TO REQUEST MY MEDICAL INFORMATION

_____ _____ /_____ /_____
PATIENT FULL NAME DATE OF BIRTH

_____ _____ - _____ - _____
STREET ADDRESS SOCIAL SECURITY NUMBER

_____ (_____) _____ - _____
CITY / STATE / ZIP PHONE (HOME /CELL)

I, _____, DO HEREBY AUTHORIZE

PRACTICE NAME: _____

FAX NUMBER: _____

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:

BLOOM OB/GYN, LLC
FAX: 844-768-4889 / PHONE: 202-449-9570
4001 Brandywine St. NW Suite 300
Washington, D.C. 20016

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