



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT FULL NAME

____/____/____
DATE OF BIRTH

STREET ADDRESS

____ - ____ - ____
SOCIAL SECURITY NUMBER

CITY / STATE / ZIP

(____) ____ - ____
PHONE (HOME /CELL)

I, _____, DO HEREBY
AUTHORIZE

_____ 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:

DR. _____ / Fax # Records Are Sent 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