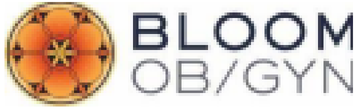

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____ _____ /_____ /_______

PATIENT FULL NAME DATE OF BIRTH

____ ________ - ________ - _______

STREET ADDRESS SOCIAL SECURITY NUMBER

____ (_______) _______ - _________

CITY / STATE / ZIP PHONE (HOME /CELL)

I, ____, DO HEREBY AUTHORIZE **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:

_____________________________________ _____________________________________

FACILITY NAME ADDRESS

_____________________________________ _____________________________________

PHONE FAX

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