INDIANA UROGYNECOLOGY

CONSENT FOR RELEASE OF MEDICAL INFORMATION

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Patient Name: _____ Physician: _____

Address: _____
Street City State Zip

Birth Date: _____ Social Security #: _____ Phone #: _____

Authorized to Release:

_____
Releasing Information

_____
Address

_____
City/State/Zip

_____
Phone/Fax

Authorized to Receive:

_____
To Receive Information

_____
Address

_____
City/State/Zip

_____
Phone/Fax

What information to send: _____ a complete copy of the above-named patient's Medical Records, including all records related to mental health, drug or alcohol condition, sexually transmitted disease or HIV status.

_____ specific, send only: _____

Reason for Transfer of Records: _____

I understand that this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. I understand that consent will expire in 60 days. Southside OBGYN, its employees, and contracting physicians are released from liability for the release of the above information to the extent indicated and authorized herein. I understand that there may be a charge for copying of these records and/ or films. A photocopy or facsimile of this authorization shall be as valid as the original.

_____ _____
Patient Signature Date **Witness Signature** Date

By signing this consent, I affirm that I am 18 years of age or older. If I am 18 years, my parent or legal guardian gives consent for transfer of records, in this case, this person attests that they are, in fact, the legal representative of the minor.

_____ _____
Parent/Guardian Signature Date Date Received by Medical Records