BROOKSIDE
gynecology

Authorization for Release of Woman's Health Information

Print Full Name_____ Date of Birth_____

Home Address_____

Home #_____Cell#_____

I hereby authorize Brookside Gynecology to: release obtain discuss (please circle information)

Medical Information (which may include all or specific information): to from (please circle information)

Provider/Group Name_____

Address_____

City/State/Zip_____

Phone_____ Fax_____

Release the following information: The most recent office notes, lab results, physical findings, Pap smear, radiology reports and medication list.

Any additional information: _____

Under State and/ or federal guidelines, certain diagnosis and treatment, may NOT be released without specific authorization. **Initial below if you WANT the information released.**

I authorize the release of information concerning drug or alcohol abuse:

I authorize the release of information concerning psychiatric treatment:

I authorize the release of information concerning HIV/AIDS testing/treatment:

I have read and understand this authorization. I consent to disclose the above information to the person/agencies listed above. I release Brookside Gynecology from all legal responsibility that may arise from the release of records. This is valid for one year from the date signed below.

Patient's signature:_____ Date:_____

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