Authorization for Release of Health Information

1. I hereby authorize ____
   Address ____
   ____

   to release the following medical records to Carteret Ob-Gyn Associates.

   Patient Name ______________________ Date of Birth ______________
   Address ______________________ Telephone ______________
   ______________________ Patient MR# ______________

   covering the period(s) of healthcare:
   From (date) ______________ to (date) ______________
   From (date) ______________ to (date) ______________

2. Information to be disclosed:

   □ Complete health record(s) (all medical information)

   Or disclose only the following:

   □ History & physical examination
   □ Progress notes
   □ Consultation reports
   □ Laboratory tests
   □ Photographs, videotapes, digital or other images
   □ X-ray reports
   □ Discharge summary
   □ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
   □ Behavioral health service/psychiatric care
   □ Treatment for alcohol and/or drug abuse
   □ Other (please specify) ____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following day, event or condition:

   ____

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: ____
(Patient's signature) (date)

____
Or (legal representative) (relationship to patient) (date)

____
(Signature of witness and title) (date)

Translated by ______________________________.
Patient acknowledges understanding. ________