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Use For: Another party
Releasing records to AG

Authorization Form for Release of Confidential Health Information

I, _____, hereby authorize:
Name of Patient or Authorized Representative

_____
Name of Health Care Facility, Physician, etc.

_____
Street Address, City, State and Zip Code

To Release to Antheia Gynecology the following information below contained in the patient record of:

_____, DOB _____
Patient's Name *Birthdate*

Residing at _____
Street Address, City, State and Zip Code

PLEASE RELEASE THE FOLLOWING RECORDS:

☐ COMPLETE RECORDS ☐ RADIOLOGY REPORTS
☐ OPERATIVE REPORTS ☐ PATHOLOGY REPORTS
☐ LAB REPORTS ☐ OTHER (SPECIFY) _____

_____ _____
PATIENT SIGNATURE **DATE OF AUTHORIZATION**

If you are not the patient, please specify relationship to the patient: _____

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION.

BY SIGNING THIS FORM, I AUTHORIZE YOU TO RELEASE COPIES OF MY MEDICAL RECORDS. I UNDERSTAND THAT THIS MAY INCLUDE INFORMATION REGARDING MEDICAL, SURGICAL, PSYCHIATRIC TREATMENT, DRUG TREATMENT, HIV TESTING, TESTING AND/OR COUNSELING.