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Use for: AG releasing records TO another party

Authorization Form for Release of Confidential Health Information

I, _____, hereby authorize Antheia Gynecology to release records **TO**:
Name of Patient or Authorized Representative

_____
Name of Health Care Facility, Physician, etc.

_____
Street Address, City, State and Zip Code

_____ _____
Phone *Fax*

Please release the Information below contained in the patient record of _____
Patient's Name

DOB _____, residing at _____:
Birthdate *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 your 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.