OB/GYN
ASSOCIATES OF ERIE

2315 Myrtle Street
Suite 220
Erie, PA 16502
(814) 454-8185
Fax (814) 454-3894

100 Peach Street
Suite 300
Erie, PA 16507
(814) 459-1851
Fax (814) 456-0541

406 West Oak Street
Titusville, PA 16354
(814) 827-7229
Fax (814) 827-4869

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____

Print Patient Name   Date of Birth   Social Security #

I HEREBY AUTHORIZE:

____

(Doctor/Group/Clinic Name)

____

(Address)

____

(City)   (State)   (Zip)

TO RELEASE INFORMATION IN MY MEDICAL RECORDS. PLEASE INCLUDE:

_____ All my medical records INCLUDING mental health/alcohol and/or drug abuse/HIV/STD.

_____ All my medical records EXCLUDING mental health/alcohol and/or drug abuse/HIV/STD.

_____ Specific records ____ Date ____________________

THESE RECORDS ARE TO BE SENT TO:

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FOR THE PURPOSE OF:

___ Second Opinion   ___ Copy to Family Physician   ___ Insurance Purpose   ___ Relocation

___ Transfer Care to Another Physician/Practice   ___ Other, Please describe ____

This consent is valid for sixty (60) days, unless revoked by me in writing or verbally before the release of the designated information. Information disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified above and is no longer protected by federal privacy regulations.

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Patient Signature   Date