Chart #____________

Name of Patient: ______________________________ Date(s) of service:_________TO____________

Date of Birth: _________________ Social Security #:__________________________

Patient Phone #:____________________________ Patient Maiden Name:______________________

I, The undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other:_______________
Legal Purposes	School	_______________
		_______________

INFORMATION TO BE RELASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other:_______________

The above information may be released :

TO: (Name, Address, Phone Number)

HIGHLAND OBGYN 2301 ROBESON ST SUITE 201 FAYETTEVILLE NC 28305

PHONE: 910-485-1191 FAX: 910-485-6006

FROM: (Name, Address, Phone Number)

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I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS, cancer, syndromes, and all lab results which may be included in my records.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Printed Name:______________________________

Signature:_________________________________ Date:____________________

Highland Witness:___________________________ Date:____________________