# ARBORETUM OBSTETRICS & GYNECOLOGY

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____

Date of Birth_____

Patient Address_____

_____

Please circle which applies to you and fill in the information:

I authorize ARBORETUM OBSTETRICS & GYNECOLOGY to obtain my records from:
I authorize ARBORETUM OBSTETRICS & GYNECOLOGY to release my records to:

Name_____

Telephone Number_____

Fax Number_____

Address_____

NOTICE TO TRANSFERRING PATIENTS: In an effort to improve our customer service, please provide your reason for transfer:

_____

_____

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This form hereby releases the sender from all legal responsibility or liability of the release of information described above from my records. Disclosure of this information without written consent by me is prohibited by federal law.

I understand that I may revoke this consent at any time. I also understand that this authorization shall expire without express revocation, three months from the date below.

_____
Patient Date