

Raleigh OB-GYN Centre, PA

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I authorize Raleigh OB/GYN Centre to obtain my medical records as indicated below.

_____ Complete Medical Record
or
_____ Records pertaining to _____
(medical problem or specific dates of treatment)

___ I do ___ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and /or psychological assessment, and treatment for alcohol and/or drug abuse.

This information is to be obtained from: _____

PURPOSE OF DISCLOSURE:

___ Continuation of Care	_____ (Name of Physician or Facility) Required information
___ Change of Doctor	_____
___ Disability Determination	_____ (Street Address & Suite #) Required information
___ Insurance	_____
___ Legal Investigation	_____
___ Personal	_____ (City, State & Zip) Required information
___ Referral to Specialist	_____
___ Worker Comp	_____
___ Other _____	_____ (Phone # / Fax #) Required information

Patient Name: _____ Date of Birth: _____
(Please Print)
_____ SSN #: _____
(Current Address) _____
_____ Phone #: _____

Patient's Signature: _____ Date: _____

Parent/Guardian (If a minor) _____ Date: _____

Witness: _____ Expiration date of consent _____