WEST KENDALL OBGYN

MEDICAL RECORDS RELEASE FORM

RELEASE FROM		RELEASE TO	
	Doctor Name:		Doctor Name:
	Address:		Address:
	Phone:		Phone:
	Fax:		Fax:

Patient's Name: ____ Date of Birth: __________________________

Social Security #: _______________________________________

Reason for Request: ____

General Information Requested

- ❑ Complete Record
- ❑ Labs
- ❑ Other ____

I request and authorize the release of information to individual named above. I understand that the information to be released may include the following condition(s):

1. Drug abuse / Alcohol abuse (federal regulation 42 C.F.R., Part 2)
2. Psychological/Psychiatric conditions
3. A test for H.I.V. (A.I.D.S.) virus
4. An A.I.D.S. diagnosis and or A.I.D.S. related condition(s).

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Signature Date Signed