MEDICAL RECORDS RELEASE

Patient Name: ____ DOB: ____________________

I authorize: ____
____
______________ to release to:

Seasons of Life Obstetrics & Gynecology, PC
1611 Pond Road
Suite 102
Allentown, PA 18104

all pertinent information regarding my treatment during the period from

____________________________________ to __________________________________.

Comments: ____
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I understand that this information may include: lab results, radiology reports, office notes, consultations from other healthcare providers and/or records of treatment for psychiatric, psychological, substance abuse, alcohol abuse, or HIV-related conditions.

I understand that this authorization is limited to, and does not allow for further release of, information by the requesting party.

Patient Signature: ____

Date: ____

Witness: ____