Chike Obianwu, MD, FACOG, FACS
Susan Ritorto, APN, MSNP
Kathleen Lindemuth, WHNPC
Shayan Khorsandi, MD
Emily Johnson, CNM, APN
Jennifer Gobencion, CNM, WHNP-BC

5045 RT 130 S, STE I Delran, NJ 08075
400 Creek Crossing Blvd. Suite 412 Hainesport, NJ 08036
Phone: 856-764-7660 Fax: 856-764-5723

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION/ THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

Patient's Name: _____ Date of Birth: _____

Previous Dr. Name: _____ Phone #/Fax # _____

I request and authorize _____ to release healthcare information of the patient named above to:

Alliance OB/GYN Consultants, LLC Fax No: 856-764-5723
5045 Route 130 South, Suite I
Delran, NJ 08075

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____