CONSENT FOR RELEASE OF MEDICAL INFORMATION

I authorize **Modern Gynecology**, or any of its employees, staff, or agents, to use and disclose health information from the records of:

Patient Name: _____ **DOB:** _____

Address: _____

Date(s) of Treatment: _____

Release Information To:

Name/ Organization: _____

Address: _____

Fax Number: _____

Information to be Released (check all that apply):

- ☐ Office/ Clinical Notes
- ☐ Procedure Notes
- ☐ Lab/ Path Reports
- ☐ Imaging Reports
- ☐ Billing
- ☐ Other: _____
- ☐ HIV/ AIDS or related info (*special consent & signature required*) _____
- ☐ Cash paid services: ie. Hormone Pellet Therapy (*consent & signature required*) _____

Purpose of Release:

- ☐ Continuing Medical Treatment
- ☐ Litigation/ Review
- ☐ Insurance (Company): _____
- ☐ Other: _____
- ☐ Personal Use

I understand my records are confidential and cannot be released without my written consent, except as permitted by law. Information released may include history, diagnoses, or treatment of drug/alcohol abuse, mental illness, or communicable disease (including HIV/AIDS), and may be subject to redisclosure.
I may revoke this authorization in writing at any time, except where action has already been taken. This authorization expires **6 months from the date signed** unless revoked earlier.

Patient Name (print): _____

Signature of Patient: _____ **Date:** _____

If signed by legal representative, print name/relationship: _____

Signature: _____ **Date:** _____

**Please allow several business days for processing. A $25 fee applies for second copy requests.*

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