PREMIER WOMEN'S HEALTH SPECIALISTS

Authorization for Disclosure of Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

The undersigned hereby authorizes and requests from:

Name: _____ Fax: _____

Address: _____

To Provide to:

Name: _____ Fax: _____

Address: _____

Please indicate what specifically is to be released:

( ) Entire Medical Record ( ) Mammography ( ) Laboratory Tests ( ) Operative Reports

( ) Pathology ( ) Other: _____

Covering record time period from _____ to _____ and hereby release Premier Women's Health Specialists from all legal liability that may arise from further disclosure of said records.

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing, and/or HIV testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for (60) days from the date stated below, unless revoked in writing by the person to which it pertains (or his/her legal guardian or legally authorized agent), to the staff of Premier Women's Health Specialists.

Patient/Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____