



Authorization for REQUEST of Medical Records

Patient's Name (print) Date of Birth

Street Address City
State Zip Code

Phone Number

I do hereby authorize:

Name of Facility

Address City
State Zip Code

Phone Number Fax Number

To Release (check all that apply):

- Entire Record Lab Reports: specify, if needed Hospital Records
Pap Smear Pathology Ultrasound Office Notes Mammogram report
Mammogram Images (CD) & Report Bone Density Other:

I do I do NOT Authorize release of information related to AIDS (acquired immunodeficiency syndrome or HIV (human immunodeficiency virus) infection, sexually transmitted disease(s), psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.

Send Records to: Green Valley Ob/Gyn (336) 378-1110
336-378-9986

Name of Facility Phone Number Fax Number
719 Green Valley Road, Suite 201 Greensboro, NC
27408
Address

Purpose of Disclosure:

- Referral to Specialist Insurance Legal Issue Disability
PCP/Internist Personal Change of Provider Worker's Compensation
Other:

I do hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

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Signature of Patient or authorized representative

Date