# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Print Patient's Full Name | Birth Date (Mo/Day/Yr)

_____ _____
Street Address | Other Names Used

_____ _____
City, State, Zip | Phone

**** At the request of the individual, I, _____ do here authorize:**

_____ _____
Name of Company/Agency/Facility/Person | Phone Number

_____ _____
Street Address City, State, Zip | FAX Number

| | | |
|---|---|---|
| **To Release to**: (fax preferred) | **Arbor Obstetrics & Gynecology** (UWH of the Carolinas)<br>**2615 Lake Drive, Suite 201**<br>**Raleigh, NC 27607** | **Fax: 919-781-1070**<br>Tel: 919-781-9555<br>Web: arbor-obgyn.com |

___ All Prenatal Records ___ Pathology Reports ___Emergency Room Notes

___ Laboratory Reports ___ Discharge Summary ___ Operative Notes

___ Radiology Reports ___ Entire Record ___ Other: _____

**During the time period of** _____ to _____

_____ **I DO** _____ **I DO NOT** authorize release of information related to AIDS/HIV infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse

**** Purpose of Record Release**:

___ Prenatal Care ___ Needed for Consultation with ObGyn ___ CoManagement of care with Arbor ObGyn

___ Transfer of all ObGyn Care to Arbor ObGyn ___Insurance Requirement ___ Personal Records

___Other (Specify) _____

**Please provide current daytime telephone number in the event we need to contact you**: _____

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

X_____ _____
**Signature** of Individual or Guardian or Personal Representative of Patient's Estate **Date**

*Rev 01/18/25*