Sussman OB/GYN LLC / TLC WOMENS HEALTH

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Date: _____

Patient's Name: _____ Date of Birth: _____

I authorize and request the above name physicians to release my medical records, including lab results: (Please write name, phone number, fax number and address)

_____

_____

_____

I understand that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis. I **understand that these individuals may call at any time and request information or Results of any testing and/or schedule any appointments.**

Also the office may Contact them for any schedule changes or any results.

I have a right to revoke this authorization in writing at any time,
Except to the extent information has been released in reliance upon this authorization.
The information released in response to this authorization may be re-disclosed to other parties.
My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or 1 of 2 immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Signed_____ Date _____

Legal representative (relationship to patient) _____

Witness_____ Date _____

Patient's Signature: _____ Witness: _____