SUSSMAN OBGYN LLC / TLC WOMENS HEALTH

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize: (name of who we want to get records from)

_____

Phone #_____fax #_____

To disclose the following information from the health records,
For the purpose of continuation of medical care,
To **SUSSMAN OBGYN LLC/ TLC WOMENS HEALTH**

Patient Name: _____ Phone: _____

Social Security #: _____ Birth date: _____

( ) History and Physical Exam
( ) Discharge Summary
( ) ER Physician Note / ER Labs
( ) Operative Report
( ) Progress Notes – Last _____
( ) Laboratory Reports
( ) Mammogram ( ) DEXA Scan
( ) Pathology Report

( ) Other _____

_____

I understand that this may include treatment for physical & mental illness, alcohol/drug abuse &/or HIV/AIDS test result or diagnosis. This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on authorization. Unless otherwise revoked, this authorization will expire 90 days from the date the authorization was signed. The facility, its employees, officers, and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed_____ Date _____

Legal representative (relationship to patient) _____

Witness_____ Date _____