

Robert Ferris, M.D., F.A.C.O.G.
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Sarah Dunn, D.O.



Kevin Bredeman, D.O., F.A.C.O.G.
Brian Stephens, M.D., F.A.C.O.G.
Lisa Graessle, Nurse Practitioner

Consent to Release / Obtain Health Information

Patient Name: _____ Former Name: _____
(Last Name) (First Name) (M)

Address: _____ City: _____ State: _____ Zip: _____

(_____) _____ - _____ - _____
Area Code Home Phone Social Security Number Date of Birth

I authorize: _____ Fax #: () _____
(Name of Organization)
_____ Phone: () _____
(Address)

(City, State, Zip)

TO DISCLOSE THE FOLLOWING HEALTH INFORMATION

I understand that the information disclosed may contain matter that is protected by federal and state laws. This information may include records related to: STD's HIV/AIDS, mental health and substance abuse. I authorize the release of the following information:

- All medical records, **INCLUDING** sexually transmitted disease (STD's), HIV/AIDS, Mental health illness/ treatment and substance abuse records.
- All medical records, **EXCLUDING** STD's HIV/AIDS Mental Health Substance Abuse

I specifically consent to release and disclose the following information:

Only records of (specify): _____

PURPOSE OF THIS RELEASE INFORMATION

TO: _____ Fax #: () _____
(Name of Organization)

_____ Phone: () _____
(Address)

(City, State, Zip)

This authorization may be revoked at any time except to the extent already relied upon, and unless earlier revoked by written notice filed with the Health Data Services Department. This authorization shall expire in 90 days. I release the clinic/provider and its staff from all legal responsibility that may arise from release information.

I understand that there may be a fee to the patient to obtain or transfer their records, pursuant to state law. _____

(Patient Signature) _____ (Date) _____

(Witness Signature) _____ (Date) _____