

## CONSENT TO RELEASE MEDICAL RECORDS

NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

- I hereby authorize and consent to the release of medical records obtained in the course of my treatment at **LGH-WomanHealth**.  
for the period of \_\_\_\_\_  
and furnish records to \_\_\_\_\_  
for the purpose of \_\_\_\_\_
- The specific information to be disclosed is:  
\_\_\_\_\_ Progress notes \_\_\_\_\_ Hospital Records \_\_\_\_\_ Laboratory Reports \_\_\_\_\_ X-ray Reports  
\_\_\_\_\_ Other (indicate) \_\_\_\_\_
- If my initials appear here \_\_\_\_\_, I specifically authorize release of drug, alcohol abuse, sexually transmitted disease and/or psychiatric records.
- If my initials appear here \_\_\_\_\_, I specifically authorize release of my HIV test results for the purpose set forth above. My signature below indicates I have read this consent form, have asked all the questions I have about the reason for the release of my identity as a test subject and the results of my HIV testing, and I agree to the release of this information to the above named party.
- If my initials appear here \_\_\_\_\_, I specifically authorize release of my records that contain information about my diagnosis of, or treatment of AIDS or contain some other reference to my identity as an AIDS patient for the purpose set forth above.
- I have carefully read and understand the above statements to herein voluntarily consent to disclose the above information about, or medical records of my condition to those persons or agencies named above. I hereby release **LGH-WomanHealth** from all liability that may arise from the release of these medical records.
- I understand this consent is subject to revocation at any time except to the extent action has taken reliance thereon. This authorization will expire 90 days from the date shown below.

Date \_\_\_\_\_  
(Signature of patient, responsible person, or parent of minor)

Witness \_\_\_\_\_

Office Form 007  
Reviewed 01/2005  
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