Obstetrics & Gynecology South, Inc.

3533 Southern Blvd.
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Kettering, OH 45429

Phone (937) 296-0167
Fax (937) 297-2330

RELEASE OF INFORMATION AUTHORIZATION

Patient Name: ____ Date of Birth: ___________

Other names that may have been used: ____

Address:____

Social Security #: _____________________________ Phone #: ____________________________

I, the undersigned, hereby authorize release of the following information:

_____ All of my medical records, including information regarding the treatment of psychological, HIV testing or AIDS related conditions, *alcohol or drug abuse and sexually transmitted diseases

_____ Only pregnancy information from ______________ to ________________
month year month year

_____ Only gynecological information from ______________ to ________________
month year month year

_____ Other information: Specify information to be released: _____________________________

*This information has been disclosed to you from records protected by the Federal confidentiality rules. Federal Regulation (42 CFR Part 2) prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

Please specify to whom you would like this information released TO:

Name: ____ Manner: __ Mail___ Phone ___ Fax

Address:____

Phone: _______________________________________ Fax: __________________________________

Please specify to whom you like this information released FROM:

Name: ____ Manner: __ Mail___ Phone ___ Fax

Address:____

Phone: _______________________________________ Fax: __________________________________

The reason for this release is: ____

This consent will expire 60 days from the date written below. Allow 7-10 business days from the receipt of this request for your records to be copied. Records sent directly to the patient are subject to a $25 fee. It is understood that this consent is subject to revocation by me at any time except to the extent that action has already been taken based on this authorization.

__________________________________ __________ ________________________________

Signature Patient, Parent/Legal Guardian Date Witness Signature

Art Altman, M.D.
Sunita Reddy, M.D.
Cathy Liesner, M.D.
Susan Komorowski, M.D.
Emily Kimble, M.D.