OBGYN
Specialists of Columbus

Ruthann F. Rees, M.D., Ph.D., FACOG

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____

Maiden Name: _____

DOB: _____ **SSN:** _____

I request and authorize _____ **to release health care information of the patient named above to:**

Physician/Practice/Patient:

_____

Address: _____

Telephone: _____ **FAX:** _____

This request and authorization applies to:

{ } Health care information relating to the following treatment, condition or dates:

_____

{ } All health care information

{ } Other _____

I understand that this information may include reference to or treatment of drug or alcohol abuse, psychological illness, or test results for HIV/AIDS. I understand that there may be a charge for these records and that there is a customary processing period. I further understand that I may revoke in writing this consent at any time.

Purpose of disclosure:

{ } Continued Health Care **{ } Legal** **{ } Other**

{ } Insurance **{ } Personal Reasons**

Patients Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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