Release of Medical Information

TO THE STAFF OF ADVANCED OB/GYN:

I give my permission to release information regarding test results and to discuss any treatment for my care received in your office. I additionally request that this person or persons have the availability to discuss any billing issues for the treatment that I have received.

Name or Names:

_____

_____

Patient Name (Print): _____

Patient Signature: _____

SS#: _____DOB: _____

Today's Date: _____

PLEASE INDICATE IF YOU CONSENT TO HAVING RESULTS LEFT ON YOUR VOICEMAIL

YES _____

NO _____