SAINT LOUIS ASSOCIATES IN OB/GYN INC.

BOARDCERTIFIEDINOBSTETRICSANDGYNECOLOGY
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AUTHORIZATION FOR REQUEST/RELEASE OF MEDICAL RECORDS

Patient Information:

Name: (Please Print) _____
Last First Middle Initial Maiden (if applicable)

Birth Date: _____/_____/_____
Month Day Year

I hereby request and authorize the release of my Medical records:

From: **Name: _____**

Street: _____

City: _____ State: _____ Zip: _____

Phone: (____)____-_____ **Fax: (____)____-_____**

To: **Name: _____**

Street: _____

City: _____ State: _____ Zip: _____

Phone: (____)____-_____ **Fax: (____)____-_____**

Records to be released: (Please Specify)

All: _____

Or

_____

Reason For Request:

Transfer of Care ____
Second Opinion ____
Primary Care Physician ____
Other _____

_____ **_____**
Signature of Patient or Guardian **Date** **Signature of Witness** **Date**