

**Ob-Gyn Specialists, P.C.**  
432 King Drive, Waterloo, IA 50702  
Phone: 319-234-5764 Fax: 319-234-1336

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**  
(PLEASE COMPLETE IN FULL)

**1. Patient:**

NAME:	LAST	FIRST	MI	DATE OF BIRTH
STREET ADDRESS				SOCIAL SECURITY #
CITY	STATE	ZIP	PHONE	

**2. Authorize Records Released From:**

NAME	PHONE	FAX	
STREET ADDRESS	CITY	STATE	ZIP

**3. Records Released To:**

NAME	PHONE	FAX	
STREET ADDRESS	CITY	STATE	ZIP

**4. Type or extent of information to be released:**

Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS related information which must be specifically authorized below:

I SPECIFICALLY AUTHORIZE the release of confidential information relating to:  
(Place **YES** or **NO** in ALL applicable boxes:)

\_\_\_\_\_ Substance Abuse (Drug or Alcohol) information

\_\_\_\_\_ Mental Health Information

\_\_\_\_\_ AIDS-related information, Diagnosis, and test results

Or ONLY the following information: \_\_\_\_\_

**5. Purpose or need for release:** \_\_\_\_\_

**6. This authorization will remain in effect for one year from the date the authorization was signed.**

**7. This authorization will be effective for medical records generated to the date of signature.**

I understand I may revoke this authorization at any time by providing my written revocation.

**SIGNATURE OF PATIENT** (If signed by person other than patient, state relationship to patient) **DATE**

Patient is: <input type="checkbox"/> Minor <input type="checkbox"/> Incompetent <input type="checkbox"/> Deceased Legal Authority: <input type="checkbox"/> Parent or Legal Guardian <input type="checkbox"/> Next of Kin of Deceased
--

2/2002