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REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
_____
_____

I hereby authorize you to release medical records on:

(D.O.B)

Pt:

Please mail records to: **St. George OB/GYN**
295 S. 1470 E. #300
St. George, UT 84790

Or fax to: **(435) 674-0960**

In addition to the general authorization to release records to the person(s) or entities listed above, I authorize the release of the records described as the following:

___ Yes ___No COMMUNICABLE DISEASE-RELATED INFORMATION, INCLUDING RECORDS OF TESTING, DIAGNOSIS, OR TREATMENT OF HIV, HIV-RELATED ILLNESS, AIDS, AIDS-RELATED DISEASE

___Yes ___No DRUG AND ALCOHOL TREATMENT

___Yes ___No PSYCHOLOGICAL/PSYCHIATRIC INFORMATION, INCLUDING DIAGNOSIS AND TREATMENT

___Yes ___No PATHOLOGY SLIDES, X-RAYS, VIDEOTAPES, PHOTOGRAPHS

___Yes ___No GENETIC SCREENING

Information to be released: (Please check all that apply including specific date range) This authorization will expire _____ or upon 1 year from date of execution and the undersigned may revoke this authorization in writing.

_____ Entire Medical Record
_____ Hospital Stay/Discharge/Operative Report
_____ Immunizations
_____ Lab &/or Pathology Report(s)
_____ Prior Delivery
_____ Other

Signature: _____ Date:

Patient / Guardian

Witness: _____ Date: