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

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name:
____

Maiden Name:
____

DOB: ______________________________ **SSN:** ______________________________________

I request and authorize OB/GYN Specialists of Columbus 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.

2000 10th Avenue, Suite 380, Columbus, GA 31901
Phone: 706-324-0471 Fax: 706-324-0473
www.obgynsoc.com

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Purpose of disclosure:

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

{ } Insurance **{ } Personal Reasons**

Patients Signature: ___________________________________ Date: ______________

Witness Signature: ___________________________________ Date: ________________

Please fax to our secure fax number (706) 324-0473

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