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.

1604 12th Street Columbus, GA 31906 Phone:
706-324-0471 Fax: 706-324-0473
www.obgynsoc.com

OBGYN
Specialists of Columbus

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

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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