Southern Indiana OBGYN

Consent for Release of Information

Patient Name: _____ Date: _____
Birthdate: _____ Social Security Number: _____
Address: _____
Telephone #: _____

RELEASE INFORMATION FROM SOUTHERN INDIANA OB/GYN
To:_____
Address:_____
Phone #: _____ Fax #: _____

OR

SEND INFORMATION TO SOUTHERN INDIANA OB/GYN
2450 North Park Dr., Suite A, Columbus, Indiana 47203
812-376-3311 Fax: 812-376-4125
From: _____
Address: _____
Phone: _____ Fax: _____

Information to be released:

- ❑ Contents of entire chart including alcohol abuse, mental health and infections
- ❑ Exclude information on alcohol abuse, mental health and infectious disease
- ❑ Include information from other physicians, facilities etc.
- ❑ Other specific information: _____

PURPOSE OF RECORDS RELEASE: _____
I understand this consent can be revoked at any time with written notice except to the extent that disclosure made in good faith has already occurred in reliance upon this consent. This consent will expire in thirty (30) days.

This facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent and authorization herein.

Patient Signature: _____

Signature of Patient Representative: _____

Relationship to Patient: _____