Partlow-Harbin and Poist OB/GYN, M.D., P.C.

701 University Blvd. East, Suite 502
Tuscaloosa, AL 35405
Phone (205) 349-4131
Fax (205) 759-2569

Consent to Release Information

Name: _____ Request Date: _____

Mailing Address: _____ Date of Birth: _____

City/State/Zip: _____ Social Security Number: _____

I authorize:

Name:	**Partlow, Harbin and Poist OB/GYN, M.D., P.C.**
Address:	**701 University Blvd. East Suite 502**
City/State/Zip:	**Tuscaloosa, AL 35405**
Phone: (205) 349-4131	**Fax: (205) 759-2569**

☐ RELEASE Information TO

☐ OBTAIN Information FROM

(Place an "X" in the box indicated if the information is being released OR requested)

Name: _____

Mailing Address: _____

City/State/Zip: _____

Phone: _____

The **Purpose of this Authorization** is indicated in the box(es) below:

☐	Further Medical Care	☐	2nd Opinion
☐	Changing Physicians	☐	Legal Investigation or Action
☐	Personal-Subject to a charge		

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or obtained.)

☐	Entire Records	☐	Medical History
☐	Treatment Notes	☐	Laboratory/X-Ray Reports
☐	Prescriptions	☐	Other (Specify) _____

This authorization shall expire on _____(date or event).

I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

_____ _____

Signature of Individual or Parent/Guardian Date

Relationship to Patient: _____