

# WYOMING OB/GYN, L.L.C.

121 S. Main St.

Warsaw, New York 14569

(585) 786-8350

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## RELEASE OF RECORDS AUTHORIZATION

PATIENT'S NAME: \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

TO: \_\_\_\_\_  
(Previous Provider)

\_\_\_\_\_  
(Address)  
\_\_\_\_\_

**I request and authorize you to release health care information about the patient named above to the doctor's office printed at the top of this form.**

This request and authorization applies to:

\_\_\_\_\_ All Records

\_\_\_\_\_ Information relating to the following treatment:

\_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

Purpose for disclosure: \_\_\_\_\_

\* **EXCLUDE** the following information (please initial):

\_\_\_\_\_ Sexually Transmitted Disease      \_\_\_\_\_ HIV/AIDS

\_\_\_\_\_ Drug/Alcohol Abuse      \_\_\_\_\_ Mental/Psychiatric Illness

**I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, mental health/psychiatric disorders, or drug/alcohol abuse. If I have been tested, diagnosed, or treated for HIV (AIDS virus), STD's, mental/psychiatric illness, or drug/alcohol abuse, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.**

\_\_\_\_\_  
(Signature of patient or patient's authorized representative)

\_\_\_\_\_  
(Date)

**THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED**