

WYOMING OB/GYN, L.L.C.

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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