I, _______________________________ authorize and request the office of

Jasper OB/GYN
613 Dorbett Street
Jasper, IN 47546
812-481-2229
812-482-3993

to release my medical records to:

____

____

____

Records to be released and the dates treatment occurred:

[ ] All records: ____________________________

[ ] Lab Work: _____________________________

[ ] Pathology report: ________________________

[ ] Radiology report: ________________________

[ ] Operative report: ________________________

[ ] Other: __________________________________

Purpose for release: ____

Patient Name _____________________________________ DOB __________________

Patient Address ____

Patient Phone _______________________________ SSN _______________________

This information is to be used for the purpose of further evaluation and treatment or for communication with other parties who are specifically named above. I understand that in order to obtain or release information, my consent is necessary. This consent is effective for 60 days from the date of signature. This consent may be revoked at any time by written or oral request of the person giving the consent.

Signature of Patient/Guardian _______________________________________ Date ___________________

Witness ____ Date ___________________