Venus Gynecology, LLC

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Medical Records From the Office

Patient Name:_____

Address:_____

Date of Birth:_____ Phone:_____

Release to:

Physician Name:_____

Address:_____

Phone:_____ Fax:_____

I authorize the custodian of my medical records or other person/entity to disclose/release the following medical records – check all that apply:

- ☐ All Records
- ☐ Laboratory and/or Pathology
- ☐ Radiology Records/Reports
- ☐ Abstract and/or Summary Report
- ☐ Medical Records 1 year
- ☐ Medical Records 2 years
- ☐ Medication List/Pharmacy Records
- ☐ Other:_____

Purpose of Release:

☐ Continuing Care ☐ Legal ☐ Personal ☐ Other:_____

I understand the information released may include history or reference to psychiatric/psychological care, drug/substance abuse, sexual assault, results of tests for all infectious diseases including HIV/AIDS.

I understand that I may cancel or revoke this authorization at any time by submitting a written request to Venus Gynecology, LLC. I understand that the cancellation/revocation will not apply to information that has already been released in response to this authorization. Unless canceled/revoked, this authorization will expire 1 year from the date signed.

Printed Name:_____

Signature:_____ Date:_____