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Authorization for Release of Medical Records

Today's Date: ____/_____/_______

Patient's Name: ___________________________ SSN: _____/______/_______

Patient's Date of Birth: ____/_____/_______ Daytime Phone: (___) ______-______

Patient's Address: ____

City: ___________________ State: ______________ Zip Code: _________________

I authorize that my medical records be sent ________TO ________FROM

PREG office (circle one) Greenville Spartanburg Asheville
_______ (see addresses above)________________________

____

____

_________TO _________FROM

(Practice, Individual, Organization)

(Mailing Address)

(City) (State) (Zip)

Records requested include: ___ office notes ___ labs ___ ultrasounds ___ HSG ___ paps ___ MMG
___ operative/surgery report: type of surgery_________________ date__________ Doctor__________
___ operative/surgery report: type of surgery_________________ date__________ Doctor__________
___ operative/surgery report: type of surgery_________________ date__________ Doctor__________
___ pathology report(s) for above surgery (ies)
___ other__________________________________

This authorization places no restrictions on any information to be released. If any restrictions are to be placed on information being released, please state: ____.

PREG can only release medical records generated by this practice.

____
Signature of Patient Date

____
Witness Date

Date records released or faxed: _________________________