



S. Diaz, M.D.  
J. Carpenter, M.D.

Obstetrics Gynecology G Family Practice

Release of Information Authorization

I hereby authorize \_\_\_\_\_ of \_\_\_\_\_  
Physician Healthcare Facility

\_\_\_\_\_  
Address (City, State) ( ) - ( ) -  
Phone Fax

to release the medical information from the records of:

\_\_\_\_\_  
Patients Name / /  
DOB - -  
SSN

\_\_\_\_\_ To authorize the release of Psychiatric treatment information.  
Initials

\_\_\_\_\_ To authorize the release of Drug/Alcohol information.  
Initials

\_\_\_\_\_ To authorize the release of HIV/AIDS testing and/or treatment.  
Initials

\_\_\_\_\_ To authorize the release of OB/GYN records.  
Initials

The information to be released to:

Complete Care Center for Women, LLC.  
7107 Jahnke Rd.  
Richmond, VA 23225  
Phone: (804) 320-4967  
Fax: (804) 320-7130

The information to be released is (Itemize portions of the record and specify time period):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Notice :

- A. By signing below you are giving your permission to the above named provider to disclose confidential health care records, which may include psychiatric, drug/alcohol treatment, HIV/AIDS testing and/or treatment, Lab testing, and/or OB/GYN records.
- B. The person or identity who receives the information to which the authorization pertains, may not redisclose the information to anyone else without your separate written consent, except as permitted by law.
- C. You have the right to revoke this consent but your revocation is not effective until it is delivered in writing to the healthcare facility in possession of your records
- D. This consent will be filled with the original record.
- E. This authorization will expire ninety (90) days from the date of signature.

\_\_\_\_\_  
Patient's Signature/Responsible Party Date

\_\_\_\_\_  
Witness Date