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"Specializing in 3D/4D Ultrasound Imaging"

Authorization for Release of Medical Information

I, _____, hereby grant my permission for release of medical information between the following parties, with no limitations, including any information concerning treatment for psychiatric illness, alcohol and drug abuse, HIV test results, diagnosis of AIDS or AIDS related conditions:

FROM:_____ TO:_____

_____ _____

_____ _____

_____ _____

☐All Records ☐All PAPs ☐Lab Work ☐Operative Reports

☐Inpatient Records ☐Clinic Records ☐Emergency Records ☐Outpatient Tests

☐Other:_____

For Treatment dates of_____ to _____

All Information obtained in association with this release is to be held in strict confidence by the recipient. Any re-disclosure is prohibited without my written authorization. This consent expires in 60 days from the date signed, unless earlier expiration is specified in this space: _____. I may withdraw this authorization at any time with written notification to the parties involved.

_____ _____ _____

Print Name Date of Birth SSN

_____ _____

Date Patient/Guardian Signature

_____ _____

Date Witness