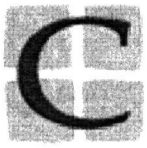

Crown OB/GYN
2056 Woodlane Dr Suite 100 Woodbury, MN 55125
Phone 651-209-0084 Fax 651-209-0388

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

DOB: _____ Phone: _____

Address: _____

_____ This will authorize Crown OB/GYN to request information from:

_____ This will authorize Crown OB/GYN to release information to:

Name: _____
Address: _____
City: _____ State: _____
Phone: _____ Fax: _____

The following information is to be released:

_____ All GYN Records	_____ Pathology Reports	_____ Pap Smears
_____ All OB Records	_____ Lab Reports	_____ Radiology
_____ Progress Notes	_____ Prenatal Records	_____ Immunizations
_____ Operative Reports	_____ H & P	_____ All

Reason for request: _____

- I understand that I may revoke this consent at any time and that the consent will automatically expire one year from the date of my signature.
- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness will be released unless initialed here _____.
- I do not authorize for further release to any third party. I understand that once the information is released pursuant to this authorization, the clinic, their employees and my physician cannot prevent the redisclosure of that information.
- I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

_____ _____ _____

Signature of Patient/Authorized Person | Relationship to Patient | Date