COLENE ARNOLD, MD
Gynecology & Associates

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Authorization to Release and Disclose Medical Information

**This authorization expires one year from the signed date below.*

PATIENT INFORMATION

Name:_____DOB:_____
Address:_____
City:_____State:_____Zip Code:_____
Phone Number(s): *Cell Phone*_____*Home*_____

RELEASE MEDICAL RECORDS *FROM*

- ☐ Colene Arnold, MD Gynecology & Associates (Dr. Colene Arnold *OR* Dr. Teresa Vanderlinde)
- ☐ Name of Company: _____
  Address:_____City:_____
  State:_____ Zip Code:_____Phone:_____Fax:_____

RELEASE MEDICAL RECORDS *TO*

- ☐ Colene Arnold, MD Gynecology & Associates (Dr. Colene Arnold *OR* Dr. Teresa Vanderlinde)
- ☐ Patient/Parent/Guardian (PICK UP or FAX ***please circle***)
- ☐ Name of Company: _____
  Address:_____City:_____
  State:_____ Zip Code:_____Phone:_____

MEDICAL RECORDS TO RELEASE

- ☐ All of my healthcare information **including but not limited to identifying information, personal and family history diagnoses, treatments, and medications.*
- ☐ The following specific health care information ***please circle***
  Evaluations - Progress Notes - Discharge Notes - Treatment Notes
  Patient Intake Forms - Billing Information
- ☐ I authorize release of records pertaining to ***please circle***
  Mental Health - Alcohol and/or Drug Abuse - HIV/AIDS
  Psychiatric/Psychological Evaluations - Chemical Dependency Evaluations

Please specify ANY healthcare information you DO NOT want released below:

PURPOSE OF DISCLOSURE

- ☐ Transfer of Care
- ☐ Continuity of Care
- ☐ Legal Purposes
- ☐ Personal Copy
- ☐ Insurance/Disability
- ☐ Other: _____

Patient Signature:_____**Date**_____