OMEGA WOMEN'S CENTER, LLC

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RELEASE OF MEDICAL RECORDS

I Hereby authorize that my medical records be released to:

To: ____
Physician or Hospital Name

____
Address

____
City State Zip Code

Please include the following information:

- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Pathology Reports
- ☐ Labor & Delivery, Prenatal Records
- ☐ Office Records

Reason for release:

- ☐ Insurance change
- ☐ 2nd opinion or consultation
- ☐ Transferring to another physician
- ☐ Moving out of area

______________________ ______________ ______________
Patient's Name (print) DOB SS #

____
Patients' name at time of procedure / Date of Procedure

______________________ / ______________________ ______________
Patient's Signature Witness Date

____ ______________
Signature of employee releasing records Date

SENT / MAILED / PICK UP __________/__________/__________