**St. Croix OBGYN**

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Phone: 340-719-9876 Fax: 340773-0600

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/Organization to Release information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific Time Of information to be Release:**

 From\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_

**Specific Type of Information to be Release:**

\_\_\_\_ Entered Chart \_\_\_\_\_ Sonograms\_\_\_\_ Labs\_\_\_\_\_\_\_ Billing\_\_\_\_\_ Progress Notes

**The purpose of the Disclosure:**

\_\_\_\_Continuing Medical Treatment \_\_\_\_ Insurance \_\_\_\_\_Attorney \_\_\_\_\_Other

This Release Authorizes the Disclosure of record 90 days from the date of execution. I understand that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information be disclosed may, I further include: Diagnosis, Prognosis, and Treatment for physical illness, including treatment of auto- immune deficiency syndrome (AIDS), AIDS related complex (ARC), Sexual Transmitted Diseases (STDs), or human immunodeficiency virus (HIV).

**THERE IS A CHARGE OF $ 1.00 PER PAGE OF THE RECORDS REQUESTED.**

I have the right to revoke this consent at any time unless the facility which is to make the disclosure of information has already done.

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**

**Physician Notification: Approve \_\_\_\_\_ Yes \_\_\_\_\_ No Why not? \_\_\_\_\_\_\_\_\_\_\_\_\_**