



Patient Name _____ **DOB:** _____

An authorization for release of medical records authorizes our office to discuss and disclose medical information to designated individuals. You may permit individuals, other than yourself, access to this information. You may also deny other individuals from receiving this information.

Please check one of the two boxes listed below.

- I would prefer that information not be given to anyone other than myself.

Patient Signature: _____ **Date:** _____

OR

I hereby authorize the release of information regarding my treatment at this office, including information regarding my illness, test results, and bills to the individuals listed below. I will hold Colorado Obstetrics & Women's Health harmless, for complying with this "Authorization for Release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. I understand that disclosure of information to a party other than the one(s) listed below is forbidden without additional authorization on my part.

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____

Name: _____

Relationship to Patient: _____

Patient Signature: _____ **Date:** _____



Dear Patient,

Your appointment today may require the collection of one or more specimens. All specimens will be sent to an outside laboratory for analysis. We will try to ensure that the specimen(s) are sent to a laboratory that is contracted through your insurance company. There will be outside fees associated with these procedures. Any laboratory fees will be billed to your respected insurance plan. You may receive a bill for those services provided by the laboratory.

Specimens that are collected and sent out for analysis include:

- Pap Smears
- Biopsies
- Tissue Samples
- Genital Culture(s)
- Urine Samples
- Blood Samples

If there is a particular laboratory you would like your specimens forwarded to, please inform us below:

I wish for my specimens to be sent to: _____

Reason(s) for specimens to be sent to this laboratory: _____

I have read and I understand the above information.

Printed Name: _____

Signature: _____ **Date:** _____