



Southern Indiana
Women, P.C. *Physicians for*

RECORDS RELEASE AUTHORIZATION

Release records from: _____
Physician or Hospital

Address/Telephone Number

I hereby request and authorize you to release:

___ Only the following tests or records: _____

___ My complete medical record - I understand that I am not required to release genetic testing or counseling results.

Release the above information to:

Physician or Hospital

Address/Telephone Number

This release is good for sixty days unless I revoke it by writing before such time.

Name: _____ Maiden Name: _____

Date of Birth: _____

Address: _____

Signature: _____ Witness: _____

Relationship of Witness to patient: _____

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