LINDSTROM OBGYN

JOSEPH LINDSTROM, M.D.

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

___ I AUTHORIZE RELEASE OF MEDICAL RECORDS FROM ANOTHER PHYSICIAN TO LINDSTROM OB/GYN
MEDICAL RECORDS FAX NUMBER 480-633-6996

___ I AUTHORIZE RELEASE OF MEDICAL RECORDS FROM LINDSTROM OB/GYN TO ANOTHER PHYSICIAN

DR/FACILITY NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

___ ALL RECORDS _____

___ OTHER RECORDS _____

Medical records shall include all confidential aids, communicable disease, HIV related information, confidential alcohol or drug abuse related information and confidential mental health diagnosis/treatment information.

Your records will be faxed one time to another physician at no charge. Subsequent requests for transfer of records will be charged accordingly. Please allow up to ten (10) business days for transfer of records. All efforts will be made to ensure the records are faxed before your appointment date.

If you request a copy of records for yourself, there will be a $25.00 copy fee for the first fifty (50) pages and/or a $50 copy fee for records containing more than fifty (50) pages.

This consent will expire sixty (60) days from the date signed below. I may revoke this authorization at any time providing I notify Lindstrom Ob/Gyn, in writing, to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I hereby release Lindstrom Ob/Gyn from all legal responsibility or liability that may arise from the act I have authorized.

PATIENT SIGNATURE _____ DATE _____

PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT _____