Advanced GYN Solutions
G. Daniel Robison, MD

State of _____ Rev. 133C89C

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient	
Address	
Phone Number	**E-mail**
Birthdate	**Social Security Number**
Other Aliases	

Name of Guardian or Legal Representative	
Address	
Phone Number	**E-mail**

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	**State**	**Zip Code**
Phone Number	**Fax Number**	

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following persons or organizations:

Person/Organization to Receive Information		
Robison Advanced GYN Solutions, PLLC		
Street Address		
1135 Military Cutoff Rd. Suite 103		
City	**State**	**Zip Code**
Wilmington	NC	28405
Phone Number	**Fax Number**	
(910) 509-0103	(910) 763-7859	

• Entire medical record (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

I further understand that my medical record may include one or more of the following:

• Treatment of communicable diseases, including sexually-transmitted diseases, tuberculosis, or hepatitis
• Treatment related to AIDS/HIV
• Mental health treatment or psychological conditions
• Alcohol or substance abuse treatment
• Genetic testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

• Change of doctor
• Continued treatment

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 1 year following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient's Signature	**Patient's** Name	Date

Guardian or Legal Representative's Signature	**Guardian or Legal Representative's** Name	Date