OB/GYN Specialists of Brevard

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I, the undersigned, do hereby authorize Edwin B. Hayes, M.D., to release to:

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The following information from my medical records:

( ) General care and treatment

( ) All lab and/or x-ray results

( ) Mental health care records

( ) Substance abuse treatment records

( ) Records relative to HIV testing/treatment for AIDS/ARC

( ) Minor Pregnancy

( ) Reportable STD's

This release covers care rendered during the time period from:

_____/_____/_____ to _____/_____/_____

I understand that this authorization is valid only for the date(s) of treatment noted above and that I may revoke this consent in writing at any time.

Patient/Guardian Printed Name: ______________________________

Signature: ______________________________ Date: ______________

Witness: ______________________________