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## **CONSENT TO RELEASE/OBTAIN MEDICAL RECORDS**

DATE	
PATIENT: FIRST NAME	LAST NAME
DATE OF BIRTH	SOCIAL SECURITY
TO RELEASE COPIES OF MY MEDICAL RECORDS  TO OBTAIN COPIES OF MY MEDICAL RECORDS	NE)
TO/FROM: NAME/BUSINESS	
ADDRESS	
PHONE	FAX
I understand that if the recipient authorized to receive the infi- care provider, the released information may no longer be pro The following information is requested and may be released:	formation is not a covered entity, e.g. insurance company or non-health tected by federal and state privacy regulations.
□ALL RECORDS	☐ Lab results (indicate date range)
$\square$ OB records only	
(indicate date range)	_ OTHER
☐ Pap smear and exam notes	
further understand that I may revoke this authorization at an the the written revocation must be signed and dated with a d	ys from the date of this authorization unless I otherwise specigy. I y time for notifying Four Corners OBGYN in writing. I also understand late later than the date on this authorization. The revocation will not ion. I understand that copies of records may be subject to a \$25.00 fee.
(Signature of Patient or Representative)	Date
(Name a	and relationship to patient if other party is signing)