Your Private MD

Release of Medical Information

I, _____, hereby authorize _____
(Patient) (Practice/Physician Name)

_____ _____ _____
(Address) (Phone) (Fax)
to release copies of medical records and other information concerning my diagnosis and treatment, including, but not limited to, information concerning treatment of drug or alcohol abuse, alcoholism, drug-related conditions, HIV testing or treatment or HIV-related conditions, psychiatric/psychological conditions. Review of records is also authorized.

All of the following information may be released or reviewed:

- Case summary
- Doctors orders and progress notes
- History and physical exam
- Lab work, x-ray reports and other testing
- Consultations
- Other: _____

*****PLEASE SEND SINGLE SIDED COPIES ONLY******

The above information is released to:

Gina Love-Walker, MD
Your Private MD, LLC
170 Taylor Station Road, Suite 210
Columbus, Ohio 43213
Phone: (614) 626-4832
Fax: (614) 626-4834

Purpose for Disclosure: To provide primary care services.

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case the consent will expire on _____.

_____ _____
Patient's Name Signature of Patient

_____ _____
Date of Birth Other person legally authorized to give consent

_____ _____
Address Relationship to Patient and reason

_____ _____
Today's Date

This information is being disclosed to the above individual/organization for the above-stated purpose from records whose confidentiality may be protected by Federal Law.