Lorraine M. Dodson, M.D.
Brian T. Stephens, M.D.

Women's Clinic of JCMG

Brandi Nichols, M.D.
Jodi A. Berendzen, M.D.
Amanda T. Rodemann, D.O.

Consent to Release/Obtain Health Information

Patient Name: _____ Maiden Name: _____

(Last Name) (First Name) (MI)

Address: _____ City: _____State: _____ Zip: _____

Home Phone: (____) _____ Social Security #: _____-_____-_____ Date of Birth: ____/____ /____

I authorize: _____ Phone: (____) _____

(Name of Organization)

_____ Fax #: (____) _____

(Address)

_____

(City, State, Zip)

TO DISCLOSE THE FOLLOWING HEALTH INFORMATION

I understand that the information disclosed may contain matter that is protected by federal and state laws. This information may include records related to: STD's, HIV/AIDS, mental health and substance abuse. I authorize the release of the following information:

☐ All medical records, **INCLUDING** sexually transmitted disease (STD's), HIV/AIDS, Mental health illness/treatment and substance abuse records.

☐ All medical records, **EXCLUDING** ☐ STD's ☐ HIV/AIDS ☐ Mental Health ☐ Substance Abuse

I specifically consent to release and disclose the following information:

☐ **Only** records of (specify): _____

TO: _____ Phone: (____) _____

(Name of Organization)

_____ Fax #: (____) _____

(Address)

_____

(City, State, Zip)

I understand that there may be a fee to the patient to obtain or transfer their records, pursuant to state law. _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____