

NORTH PARK OB-GYN Associated, PC

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**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

(PLEASE PRINT)

I, _____, hereby request and authorize North Park OB/GYN Associated, PC to release my records.

RELEASE TO:

Name: _____

Address: _____

Phone #: _____

Signed: _____ Date: _____

Witness Signature: _____ Date: _____

Date of Birth: _____

Reason for Release: _____

FAX Number 423-875-8510
North Park OB/GYN