DOCTORS EICHENLAUB AND MAY

Obstetrics & Gynecology

John J. Eichenlaub, MD · Dorothy C. May, MD · Cheri Gard, CNM, CRNP · Lisa Leitzell, CRNP

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Authorization to release/use medical information

Patient Name: ____

Date of Birth: ___/___/___ Social Security Number: ______________________

Address: ____

____

I hereby authorize: Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Fax: ______________________________

To release to: Dr's Eichenlaub and May
2128 Embassy Drive
Lancaster, PA 17603
Phone: (717) 509-5090
Fax: (717) 509-5078

any and all information regarding my physical condition and treatment rendered at any time, or during the time period specified as ______________________________

Please initial if:

__________ This authorization includes the release of HIV related and AIDs related information and test results included in the medical records.

__________ This authorization includes the release of psychiatric records, mental health records, and drug and alcohol treatment records included in the medical record.

I understand this consent is subject to revocation in writing at any time. Any revocation will not apply to information that has already been released in response to this authorization. This authorization expires in 90 days unless otherwise specified.

Patient signature ______________________________ Date ____________

Or legal guardian/custodial parent (circle if applicable)

Witness signature ______________________________ Date ____________