**William G. Bush M.D., P.L.L.C.**
OBSTETRIC & GYNECOLOGY

# Authorization of Release/Request of Healthcare Information

I authorize the release of information from the medical record of:

**Patient Name:** ____________________________________ **Date of Birth:** ____________________

**Released To / From: (circle one)**
William G. Bush, M.D.
1020 River Oaks Drive, Ste. 410
Jackson, MS 39232
Phone: (601) 664-0111
Fax: (601) 932-1308

**To / From: (circle one)**
____________________________________
____________________________________
____________________________________
Phone: ______________________________
Fax: _________________________________

[ ] Complete Medical Records

[ ] Medical Records for dates of service from ___________________ to _____________________

[ ] Lab Results: __________________________________________________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I also understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

I understand that specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

____________________________________ ______________________________________
Signature of Patient or Legal representative Date

____________________________________
Relationship to Patient

**COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO THE PATIENT**

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold William G. Bush M.D. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

______________________________________ _________________________________
Signature of Patient or Legal Representative Date

______________________________________
Relationship to patient

6/2010 Date sent: _________________ Initials: ________