CONTEMPORARY OBSTETRICS & GYNECOLOGY
132 NORTH ST
AUBURN, N.Y. 13021
PH (315) 685-1691 FAX (315) 685-1695

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of my health information as directed below:

1.) Office Name, Person or others authorized to disclose this information:

Name: _____
Address: _____
Fax #: _____

2.) Name of office or persons authorized to receive this information:

Contemporary Obstetrics & Gynecology
Dr. James Alexander MD & Danielle Lefebvre WHNP-BC
132 North St. Auburn, NY 13021
FAX # (315) 685-1695

3.) Description of Records or Information Requested: _____
_____
_____

4.) This information will be used or disclosed for the following reasons (request of patient, transfer of care, etc.): _____
_____

5.) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
6.) I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken on this authorization.

7.) This Authorization Expires on the Following Date: _____

X _____ _____
Signature of Patient **Date**

_____ _____
Printed Name of Patient **Date of Birth**