LEGENDS OB/GYN LLC

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Phone: 913-334-2880
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AUTHORIZATION TO RELEASE INFORMATION

Patient Name_____

LAST FIRST INITIAL

Address_____

STREET CITY STATE ZIP

Phone(___)_____ Date of Birth_____

I authorize _____ to release medical information from my medical record to: *Legends Ob/Gyn LLC*

8919 Parallel Pkwy Suite 403

Kansas City, Ks 66112

Fax: 913-334-2898

Entire Record____ Pathology____ Operative Reports ____

Labs ____ Specific Information _____

Radiology ____

I give special permission to release any information regarding: (initial lines below)

_____Substance Abuse _____Psychiatric/Mental Health Information

_____HIV Information

This authorization will automatically expire one year from the date signed.

Signature_____ Date_____