Constance Y. Battle, M.D., OB/GYN, P.A.

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Medical Records Release Authorization

Date: _____

Patient: _____

Date of Birth: _____

I hereby authorize Dr. Constance Battle to release to:

_____
Name/address of physician or facility

Mail to: _____

Fax to: _____

the following medical information from my medical record:

- All Mammogram results
- All Pap smear results
- Office notes from _____to _____
- X-ray/Ultrasound reports (date & type):_____
- Ct/MRI (date & type):_____
- Other(please specify):_____

This consent to release is valid for one year unless otherwise specified. I understand that at any time between the time of signing and expiration date, I have the right to revoke this consent.

Signature: _____

Date signed: _____

For office use only

Date faxed/mailed: _____

Initials: _____

Revised 3/10/2010