Center for Advanced Gynecological Surgery

FRANCOIS BLAUDEAU M.D.
3401 INDEPENDENCE DRIVE
SUITE 221
Homewood, Al 35209

CONSENT TO RELEASE MEDICAL RECORDS

The following in an authorization and request made to

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For the release of the complete medical record (progress notes, lab reports, radiology, pathology, operative notes, etc) of:

Patient Name: ____

Address: ____

Date of Birth:__________________ Social Security number:______-____-______

The records are to be sent to: Dr. Francois Blaudeau
3401 Independence drive
Suite 221
Birmingham, Al 35209
Phone# 205-930-0080
Fax# 205-802-2240

I agree to release the clinic, its employees, officer and physicians, as well as the third party contracting services from any and all liabilities and responsibility for disclosure of the above information to the extent indicated and authorized pursuant contract to release the medical record. I understand that I have the right to read the information to be released. A fee may be charged to cover cost of duplication. I also understand that I have the right to withdraw this consent by written statement at any time. This consent will expire sixty days from the date it is signed. I understand that copies may be made by a contracted copy service.

If not signed by patient, please specify relationship to patient:

____ Date:__________

Witness____ Date:__________