



1236 Huffman Mill Road, Suite 2600
Burlington, NC 27215
Phone (336) 538-2014 * Fax (336) 538-2015
Lynde Knowles-Jonas, M.D.
Board Certified in Obstetrics & Gynecology

RELEASE OF MEDICAL INFORMATION

Patient Name:	Date of Request:
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Date of Birth:	Social Security Number:
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I request that Grace Women's Clinic, PA release my protected health information to the following entity:

Facility/Physician Name: _____

Facility/Physician Address: _____

Facility Phone: _____ Facility Fax: _____

The following information is authorized to be released:

- All healthcare information
- Healthcare information related to specific dates, treatment, or condition: _____

- Other: _____

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the entity listed above. I understand that the entity listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes

NO

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the entity listed above.

Yes

NO

Patient Signature:	Date:
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