



Saint Louis  
GYNECOLOGY & ONCOLOGY

## MEDICAL INFORMATION RELEASE FORM

I, \_\_\_\_\_, HEREBY GIVE MY PERMISSION TO RELEASE ANY AND ALL MEDICAL INFORMATION CONCERNING MY MEDICAL CONDITION THAT IS BEING TREATED BY ST. LOUIS GYNECOLOGY & ONCOLOGY, LLC, TO THE FOLLOWING:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE – PATIENT

\_\_\_\_\_  
DATE

THIS RELEASE MAY BE REVOKED AT ANY TIME BY THE PATIENT -  
(If the patient decides to revoke the above release, please have them state so at the bottom of this page, sign, and date)