The Echenberg Institute
for pelvic & sexual pain

Phone: 610-868-0104 Fax: 610-868-0204

Medical Records Release Authorization

I, (*patient's name*) _____, hereby authorize
(*physician's name*) _____

To disclose the following information from the health records of:

Patient Name: _____
Date of Birth: _____
Social Security #: _____

Covering the period(s) of healthcare from:
_____ to _____

- GYN operative notes with pathology reports
- Pelvic ultrasound results
- Pelvic MRI reports
- Urinalysis reports

This information is to be released to:

Robert J Echenberg, MD
The Echenberg Institute for Pelvic and Sexual Pain
623 West Union Boulevard, Suite #5
Bethlehem, Pa 18018
Phone #: 610-868-0104
Fax #: 610-868-0204

_____ _____
Patient Signature Date