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MEDICAL RECORDS RELEASE

FULL NAME (Last, First, Middle Initial)

DATE OF BIRTH (MM/DD/YYYY)

TODAY'S DATE (MM/DD/YYYY)

MAILING ADDRESS (Street, City, State, and Zip Code)

HOME TELEPHONE NUMBER

BUSINESS TELEPHONE NUMBER

CELL # OR PREFERRED CONTACT NUMBER

REASON YOU ARE REQUESTING A TRANSFER OF YOUR RECORDS TO ANOTHER PROVIDER?

PLEASE OBTAIN INFORMATION FROM:

NAME OF PROVIDER OR ORGANIZATION:

ADDRESS:

PHONE NUMBER:

FAX NUMBER:

PLEASE SEND MEDICAL RECORDS TO:

NAME OF PROVIDER OR ORGANIZATION:

ADDRESS:

PHONE NUMBER:

FAX NUMBER:

All records from the previous 3 years will be sent unless otherwise requested. I authorize the following information to be released:

(Please initial all that apply)

Pathology Reports

Pap Smears

Mammogram Reports

Urine Cultures

Blood Work

Operative Reports

Medical Records

Office Notes

Infertility Notes

Ultrasound Reports

Bone Density

Requesting records from _____ to _____

Other

Please **Do Not** send the following records:

HIV Test Results

Drug/Alcohol Assessment/Treatment

Other: _____

Records related to Admission & Treatment for the following Medical Condition or Injury.

EXPIRATION of this Authorization expires 60 days unless otherwise notes. A duplicate of this authorization shall be valid for all purposes. This Authorization is subject to revocation at any time. This Information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no disclosure for this information without Specific, Written, & Informed release of the individual to whom it pertains, or is otherwise permitted by State Law. A General Authorization for the release of Medical or other information is not sufficient for the purpose of release of HIV Test Results or Diagnosis. We encourage patients to personally pick up copies of their medical records. Medical Records will be sent via Certified US Mail and there will be a charge for this service, unless the medical record being sent is for continuity of care and is a direct referral from our practice.

Patient Signature

Today's Date (MM/DD/YYYY)

Physician Authorization

Today's Date (MM/DD/YYYY)