GyneMedic
Obstetrics & Gynecology

Authorization for the Release of Medical Records

Patient Name: _____

Date of Birth: ____/____/_____

Address: _____

Telephone Number: _(_____)_____

Reason for medical records request: _____

_____

_____I authorize the releae of records, including those which may contain confidential information (testing, diagnosis, or treatment), confidential communicable disease related information, information related to mental health and the treatment thereof.

*please initial if you want to authorize your records to be FAXED. _____

Photocopies of information to be released:

_____ Discharge Summary _____ Operative Report _____ Pathology Reports

_____ Consultation _____ Laboratory Results _____ Mammography Results

_____ Ultrasounds _____ Other: _____

***ALL INFORMATION MUST BE COMPLETED BEFORE RECORDS ARE COPIED ***

I hereby authorize: _____

Phone #: _____ Fax#: _____

Address: _____

To be Released to: _____

Phone#: _____ Fax#: _____

Patient Signature: _____ Date: _____

Witness: _____ Copy & Delivery Date: _____/____/_____ **F or M**

If the records are forwarded to another physician due to insurance changes or medical necessity, there will be no charge. In all other situations there will be a $35.00 processing fee. Processing time for medical records is 7-10 business days. We accept cash, check or credit card (MC or Visa).