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MEDICAL RECORDS RELEASE

NAME: ______________________________ **D.O.B.:** ______________

PHONE NUMBER: ______________________________

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 with 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 or Alcohol Assessment or Treatment
___ 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)**