Medical Records Release Authorization

I ____, hereby authorize **Gyn Care** to release the following information on:

Patient Information

Patient name: ______________________________________ Birth date: ___________________________

Street address: ____

City: ____ State: __________ Zip: ______________

Phone number: __________________________________ Fax: _________________________________

Please check all information to be release:

Entire record
Registration record
Laboratory reports
Imaging reports
Medication list
Physician notes
Other: ____

Date(s) of Service
From: _________________________________ To: ________________________________

Facility Information

Information shall be released (sent) to: ____

Street address: ____

City: ____ State: __________ Zip: ______________

Phone number: __________________________________ Fax: _________________________________

Purpose for release of records:
For attorney   Personal use   Changing physicians   2nd opinion/consult   Moving
Other: ____

I understand that my records may include reference to sexually transmitted disease, alcohol or drug use and/or AIDS or HIV status, if applicable. It may also include information about behavioral or mental health status.

Include these records   **Do NOT include these records**

I understand that I may revoke this authorization at any time in writing, otherwise this consent will be considered valid for sixty (60) days. Furthermore, I understand that there may be a fee associated with honoring this request, and that payment is required before records are released.

I authorize the following individual to pick up my records: ______________________________________
(***must bring picture ID***)

Authorized signature: _____________________________________ Date: _______________________

Relationship to patient: Patient   Parent   Legal guardian   Healthcare power of attorney
(*submit signed copy*)

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