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: _________________________________

Information shall be released (sent) to:

Gyn Care
Attn: ***Medical Records Dept.***
1920 W. Sale Rd., Bldg. F, Ste. 5
Lake Charles, LA 70605
Main: (337)480-0140 • Toll Free: (800)689-2619 • Fax: (337)480-0606

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.

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*)

SUBMIT

1920 W. Sale Rd., Bldg. F, Ste. 5 • Lake Charles, LA 70605
Main: (337)480-0140 • Toll Free: (800)689-2619 • Fax: (337)480-0606
www.gyncareclinic.com