

Obstetrics & Gynecology Specialists P.C.

Medical Records Release Form

INTERNAL USE:
CHART NUMBER: _____
EMPLOYEE INITIALS: _____

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Release of Information **From:** Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Release of Information **To:** Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I am requesting the information checked below to be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> Last Routine Physical | <input type="checkbox"/> Last 1 Year of Medical Records |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Last 3 Years of Medical Records |
| <input type="checkbox"/> Delivery Records | <input type="checkbox"/> Past Surgical Records |
| <input type="checkbox"/> Final Discharge Summary | <input type="checkbox"/> Drug and Alcohol Summary |
| <input type="checkbox"/> Psychiatric Reports | <input type="checkbox"/> HIV Reports |
| <input type="checkbox"/> Laboratory Results (specify type or date _____) | |
| <input type="checkbox"/> X-Ray or Imaging Reports such as Ultrasound (specify type or date _____) | |
| <input type="checkbox"/> Other: (please specify) _____ | |

The purpose(s) of the authorization is (are)

- | | |
|--|---|
| <input type="checkbox"/> Shared Medical Care | <input type="checkbox"/> Personal File |
| <input type="checkbox"/> 2 nd Opinion | <input type="checkbox"/> Transferring of Care |
| <input type="checkbox"/> Moving out of the Area | <input type="checkbox"/> Other _____ |

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation of refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be re disclosed and will no longer be protected by the regulations. Iowa and/or Federal law provides that I have a right to prohibit re disclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I further understand that the recipient, without further authorization, may re disclose said information to: Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any said persons.

I understand this release is valid for 1 year from date of signature, unless revoked in writing by me.

Patient/Guardian Signature
(if guardian list relationship to patient)

Date