Obstetrics & Gynecology Specialists P.C.
Medical Records Release Form

OB Transfer

INTERNAL USE:
CHART NUMBER: _____
EMPLOYEE INITIALS:

Patient Name: _____ Previous Last Name (If applicable) _____

Date of Birth: _____ Phone #: _____

Release of Information **From**: **HOSPITAL NAME:** _____

CLINIC NAME: _____

PROVIDER NAME: _____

Address: _____

City, State, Zip: _____

Phone: _____**Fax:** _____

Start Date of Records: _____ End Date of Records: _____

Release of Information **To**: The Group Obstetrics & Gynecology Specialists P.C. at 5350 Eastern Avenue

Davenport, IA 52807 Phone: 563-355-1853 **Fax: 563-359-1512**

I am requesting the information checked below to be disclosed:

- ☐ All current office notes/Progress notes/Procedure Notes/H&P
- ☐ Labs (prenatal labs, STD Screenings, and an up to date pap/HPV)
- ☐ Ultrasound Reports
- ☐ ER Reports

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

☐ Shared Medical Care ☐ Moving out of the Area ☐ 2nd Opinion ☐ Transferring of Care

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.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, assault, domestic violence, genetic testing, sexually transmitted disease, HIV texting, HIV results or AIDS information.
***_____ (initials) *** INITIAL HERE

_____ _____

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

Please return form to medicalrecords@obgyngroup.com or fax 563-359-1512

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Address: _____

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Phone: _____Fax: _____

Start Date of Records: _____ End Date of Records: _____OR

All Past, Present, and Future Medical Records: ☐

Release of Information To: The Group Obstetrics & Gynecology Specialists P.C. at 5350 Eastern Avenue Davenport, IA 52807 Phone: 563-355-1853 Fax: 563-359-1512

Please mark one of the following boxes below:

- ☐ Delivery and Prenatal Records/Operative Report
- ☐ Past Surgical Records
- ☐ Laboratory Results
- ☐ Complete Medical Record
- ☐ Last 1 Year of Medical Records
- ☐ X-Ray or Imaging Reports such as Ultrasound
- ☐ Please specify any other records that are not listed: _____

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FOR OFFICE USE: ☐ Records faxed ☐ Records given to patient ☐ Records emailed

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