Highland GYNECOLOGY

Authorization for release of medical information

Patient Name:_____ DOB:_____

Requester's Name and Phone #_____

I hereby authorized and request copies of medical records from:

_____ _____

(Name of Company/Agency/Facility/Person) (Phone #)

_____ _____

(Street Address, City,State,Zip) (Fax #)

Information to be released to:

_____ _____

(Name of Company/Agency/Facility/Person) (Phone #)

_____ _____

(Street Address, City, State, Zip) Fax #)

Check Information to be Requested :

□ Entire Record

□ Immunization Records

□ TB Skin Test

□ Lab Tests

□ X-Ray Reports

□ Physical Exams

□ Discharge Reports

□ Billing Records

□ Other (specify):_____

Reason for Request :

□ Change of Doctor

□ Continuation of Care

□ Personal Records

□ Insurance

□ Consultation

□ Other (specify):_____

I would like this information to be: □ Faxed(Only shot records can be faxed) □ Mailed □ Pick Up

I understand this information is confidential and there shall be no further disclosure without the written authorization of the patient and his/her legal guardian. Multiple request may necessitate a copying fee of $25.00. Please be aware that by state law we have 14 days in which to comply with your request.

_____ _____ _____

Signature of patient/Legal/Guardian Relationship to Patient Date

Highland
GYNECOLOGY