WEST COAST
WOMEN'S SPECIALISTS

Phone: 941-745-5115
Fax: 941-750-6538

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____ Social Security Number: _____

Patient Address: _____

I hereby **REQUEST OR RELEASE (circle which apply) for medical records to be sent or obtained. Please include DR'S NAME, COMPLETE ADDRESS AND PHONE NUMBER.**

_____

_____

Disclosure will include: (**check all that apply**) ☐ ALL Dates: _____

☐ History & Physical ☐ Lab Reports ☐ Operative Reports ☐ Radiology Reports

☐ Progress/Physician Notes ☐ Pathology Reports ☐ Other: _____

Include the following: (indicate by initialing)

_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse.

_____ Records of HIV testing and/or AIDS diagnosis or treatment.

_____ Psychiatric, psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I understand that failure to initial the above three (3) items indicates that I do not want those specific records released.

I also understand the following:

- I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for Premier OB/GYN, LLC. to inform the requester that portions of the record have been withheld.
- This authorization shall remain valid unless revoked but will expire 1 year after signing. This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.
- *Premier OB/GYN, LLC. reserves the right to charge a $1 per page fee for copying of medical records up to 25 pages and $.25/page thereafter. If a fee is to be assessed, the patient will be informed of the total cost before medical record copies are made.*

_____ _____

Signature of Patient or Substitute Decision Maker Date

_____ _____

If Substitute Decision Maker, state relationship If Substitute Decision Maker, state reason

REASON FOR REQUEST:
___ MOVING OUT OF STATE
___ NO INSURANCE
___ NEW PREMIER PATIENT
___ PERSONAL RECORDS
___ TRANSFERRING CARE
REASON:

METHOD OF DISCLOSURE:
___ MAIL TO ABOVE PATIENT ADDRESS (see fees above)
___ HAND DELIVERED TO PATIENT (see fees above)
___ MAIL TO ABOVE PROVIDER (no charge)
___ FAX TO ABOVE PROVIDER (no charge)

PATIENT ACKNOWLEDGMENT OF RECEIPT OF HAND DELIVERED RECORDS:

_____ _____

Signature Date