



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 & FAX 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 WCWS 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