Alliance
Obstetrics & Gynecology

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Records Release Form

_____ _____
Patient's full name Birth date (month/day/year)

I hereby request that *Alliance Obstetrics & Gynecology Group, LLC* release my medical records to the following:

☐ myself ($1 per page up to $40)

☐ medical office (free via fax): _____ _____
Name of practice Fax number

Dates: ☐ all ☐ limited to _____

Records: ☐ all ☐ limited to _____

I do/ I do not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I hereby authorize disclosure of the health information as listed above. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request at any time, in writing, but this cancelation will not apply to previously released information. I understand that any released information is subject to re-disclosure by the recipient.

_____ _____
Signature of Patient/Responsible Party Date

Administrative Use Only

Payment Amount: $ _____ Paid: yes no

Payment Type: _____ Cash _____ Credit Card Initials: