

Medical Records Release Form

Medical Record Number: (to be filled in by practice) _____

Patient Name _____ Date of Birth _____

Address _____

Home Phone _____ Cell _____ Work _____

Email Address _____

I, _____, hereby authorize **Brandon Gynecology Associates, PA**
to release the following information:

- All Records
- Consultation Notes
- Discharge Summary
- Emergency Department Records
- Hospital Records
- Office Visits
- Pathology Lab Reports
- Radiology Reports (ultrasounds, x-rays, MRI, CT scans)
- Surgery/Operative Reports

Dates of service for requested release

- All dates
- Date Range _____ to _____

I do do not authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Release information to _____

Reason for Release:

- Moving out of the area
- Continuation of care
- Second opinion
- Personal
- Legal

Patient Signature _____ Date _____

Printed Name _____