Brandon Gynecology
ASSOCIATES, PA
Compassionate Care for Women

Request for Medical Records

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

Patient Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Work _____

Cell _____ Email Address _____

I, (NAME) _____, hereby authorize _____

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:

Brandon Gynecology Associates, PA
Mallard Crossing Medical Park
10310 Mallard Creek Road, Suite 101D
Charlotte, NC 28262-4563
O 704.510.1600 • F 704.510.1601

Patient Signature _____ Date _____

Printed Name _____