Brandon Gynecology
ASSOCIATES, PA
Compassionate Care for Women

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 _____

Mallard Crossing Medical Park • 10310 Mallard Creek Road - Suite 101D • Charlotte, NC 28262-4563
O 704.510.1600 • F 704.510.1601 • info@brandongynecology.com • www.brandongynecology.com