



Advanced ObGyn

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Phone Address: _____

Please check only one to release or obtain records below.

- I authorize Advanced OB-GYN to **RELEASE** copies of my medical records to:
- I authorize Advanced OB-GYN to **OBTAIN** copies of my medical records from.

Records are for: Check all that apply:

- Self (Patient) *Cost is \$1 for each page for the first 25 pages, and .50¢ for each page over the 25 pages with a search fee of \$5. If records are mailed, a fee for mailing records will be added.
- Transferring Care to Another Provider
- Physician / Medical Office
- Other (Person or Organization): _____

Name of Physician, Person, Organization, or Self: _____

Address: _____

Phone: _____ Fax #: _____

Check all that apply:

- Office visit notes Lab results Imaging Operative note All Records
- Other: _____

Delivery Method (check one):

- Secure Fax Patient Pickup Email (Email Address): _____

For email delivery method please read and initial below to confirm understanding.

_____ I understand that email is not a secure method of communication and accepts the risk of unauthorized access or disclosure of my personal health information.

Patient Signature: _____ Date: _____

Printed Name of Patient / Legal Representative: _____

Relationship to Patient (if applicable): _____