 **Medical Records Release Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location (City, State):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize:**

* The facility listed on this form to release information to Charlottesville Gynecology.

**OR**

* Charlottesville Gynecology to release information to the facility listed on this form*.*

For the Following : Purpose of Request:

( ) office notes ( ) medical care

( ) laboratory tests ( ) personal use

( ) radiology reports ( ) other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) pathology reports

( ) Emergency Department report

( ) operative report

( ) other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the person signing this authorization, I understand that I am giving my permission for the disclosure of confidential health

care records that may include substance use, sexual history, HIV results, psychiatric history.

I understand that I have the right to revoke this authorization. I understand that the revocation will not apply to information that has

already been released in response to this authorization. I also understand that once the information is disclosed pursuant to this authorization,

 it may be re-disclosed by the recipient and that the information may not be protected under federal privacy regulations.

I understand that treatment, payment, or eligibility for benefits cannot be conditioned on me signing this form.

A copy of this authorization will be included with my records.

This authorization is valid for 180 days after signing.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_