Ivonne Maria Reynolds, DO, LLC
OBSTETRICS AND GYNECOLOGY

REQUEST FOR MEDICAL RECORDS

I, _______________________________ _______________________
(PATIENT NAME) (DOB)

REQUEST ____
(FACILITY NAME)

Phone ______________________ **Fax** ______________________

TO RELEASE:

Dates and Type of information to disclose:

☐ Most recent office visit ☐ with labs

☐ Labs/Diagnostic results ***only*** Date: ____________

☐ Previous OB Record ***only***

☐ Complete Medical Chart ______________________

The purpose of disclosure is:

☐ Change Physician

☐Continuation of Care

☐ Change of Insurance

RESTRICTIONS: **Only medical records originated through this healthcare facility will be copied** unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization *(TO)*:

____

____

____

☐ Please mail records ☐ Please fax records.

Requesting medical records from one physician to another via fax is not affiliated with any cost. Duplication of medical records for personal records or to take to another provider incurs a cost of $1 per page up to 25 pages and .25 thereafter in accordance with Florida law.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X______________________________ ______________
Signature of Patient / Parent / Guardian or Authorized Representative **Date**

______________________________ ______________
Printed name of Authorized Representative Relationship / Capacity to patient

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