KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

# PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS

## SECTION I: Patient Information

| | |
|---|---|
| Name: | Date of Birth: |
| Address: | Social Security: |
| Phone: | **Reason for records:** |

## SECTION II: Request for specific items to be released

I request Dr. _____ to release the medical information identified below relating to my treatment during these dates: from _____ to _____

___ Cardiovascular reports ___ Emergency room ___ Pathology report ___ Consultation
___ History physical ___ Progress notes ___ Discharge summary ___ Laboratory results
___ X-ray reports ___ EKG Reports ___ Operative report ___ Complete medical records
___ Photography, videotapes, or other digital images ___ Records for Prescription Medications

___ Other (describe) _____

## SECTION III: Delivery Method

| | |
|---|---|
| ○ Hold records for pick-up; I personally will claim the records | ○ Fax to this number: (NOTE: Complete medical records will not be faxed) |
| ○ Hold for pick-up by my authorized representative Name: _____ (**NOTE:** Your authorized representative will be asked) | ○ Mail to this address: |

**SECTION IV: Duplicating Fees**

I understand there is no charge associated with having my records sent directly to another physician or provider to facilities the continuity or transfer of my care. If I have requested the records personally, there will be a charge that is allowed by law to cover the cost. The fee is $1.00 per page up to 25 pages, the $0.25 for each additional page. Charges for film duplication may be higher. This request may take up to 10 days.

## SECTION V: Release

I hereby release _____, and its employees from any and all liability that may arise from the release of the information as I have directed.

_____ _____

Signature of patient or legal guardian Date

601 N. Flamingo Road, Suite 307 • Pembroke Pines, FL 33028
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