

**\*\*Complete this form if you want your records to be sent to another practice.**

**MEDICAL RECORDS REQUEST FORM**

As required by the Health Insurance Portability and Accountability Act of 1996(HIPPA). This practice may not disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It maybe invalid if not fully completed. You may wish to ask the person or entity your want to receive your information to complete the sections detailing the information to be released and purposes for the disclosure.

I hereby authorize: **OB/GYN HEALTH CENTER** **Phone: 386-258-0123**  
**769 NORTH CLYDE MORRIS BLVD** **Fax: 386-258-6464**  
**DAYTONA BEACH FL, 32114**

To release health information of the patient named below:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Dates of service to release: \_\_\_\_\_ Entire medical Record \_\_\_\_\_

Exclusions (Please initial): Drug/Alcohol \_\_ Mental Health/Psychiatric \_\_ STD \_\_ HIV/AIDS \_\_  
 Other \_\_ Description of other exclusions \_\_\_\_\_

Reason for Release: \_\_\_\_\_

Please send records to: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Fax: \_\_\_\_\_  
 \_\_\_\_\_

This Authorization is effective this date \_\_\_\_\_ through \_\_\_\_\_ (Dates must be specified)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Print name: \_\_\_\_\_

Please Check: I am the \_\_ Patient \_\_ Guardian \_\_ Patient Representative

**\*If this form was completed by someone other than the patient, please print name and address below\*.**

Name: \_\_\_\_\_ Address \_\_\_\_\_  
 \_\_\_\_\_

**I understand that I have the right to receive a copy of this authorization**

**\*\*Records Fee\*\*** \$1.00 per page for the first 25 pages then \$.25 each additional page

Charge \_\_\_\_\_ Paid \_\_\_\_\_

