# 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: _____ P#:_____

_____ F#:_____

_____

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

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_____

*****Please mail records if it is over 50 pages*****