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 _____ Phone _____

_____ Fax_____

_____

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**
769 N. Clyde Morris Blvd
Daytona Beach, FL 32114

Phone: 386-258-0123
Fax: 386-258-6464

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

Date:_____

Signature: _____ Print name:_____

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

Please Check: I am the _____ Patient _____ Guardian _____ Patient Representative

Name: _____Relationship to Patient: _____

Address: _____

_____

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