

MEDICAL RECORDS REQUEST FORM

As required by the Health Insurance Portability and Accountability Act of 1996(HIPAA), 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 use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and purposes for the disclosure. If you wish to have your records sent to more than one provider, you must complete the form for each provider.

I hereby authorize _____ Phone _____

_____ Fax _____

To release health information of the patient named below:

Name _____ Date of Birth _____ SS# _____

Dates of service to be released: _____ 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
Encrypted email: obgynhcov@femwell.com

If the records are over 50 pages, please send them through regular mail.

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