

**Burton Danoff, MD F.A.C.O. G**  
Gynecology and Women's Health

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**RELEASE OF MEDICAL RECORDS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Telephone #: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Dr. Burton Danoff to send my medical records to \_\_\_\_\_. Telephone \_\_\_\_\_ Fax \_\_\_\_\_.

*By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.*

Please send the following records to the above address or fax:

- \_\_\_ Radiology reports regarding \_\_\_\_\_
- \_\_\_ Labs \_\_\_\_\_
- \_\_\_ Progress Notes \_\_\_\_\_
- \_\_\_ Other \_\_\_\_\_

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff of the physician.	

\_\_\_\_\_  
Patient Signature or Legal Guardian (if patient is under 18)

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