

# Medical Record Release Authorization

Patient Name \_\_\_\_\_ Maiden Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell/Work \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**I hereby Authorize:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

**To send the following information to:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

Date Range \_\_\_\_\_ to \_\_\_\_\_

- Cardiology/EKG Reports \_\_\_\_\_
- Lab/Path Reports \_\_\_\_\_
- Operative/Procedure Reports \_\_\_\_\_
- Immunizations \_\_\_\_\_
- Physicians Office Notes \_\_\_\_\_
- Radiology/XRay/MRI Reports \_\_\_\_\_

- 2 Years Entire Chart
- Other \_\_\_\_\_  
(Be Specific)

**OR**

**For the purpose of :** \_\_\_\_\_

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I gave my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient/Parent/Guardian or Authorized Representative) **(Please Read the info below)**

This authorization will expire one year from the above date unless I specify an expiration date: \_\_\_\_\_  
(Expiration date of authorization)

Women's Wellness and Gyn Surgery Center contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by The State of California which will be pre-billed to you. You will receive an invoice from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records.