



CONSENT TO RELEASE OR OBTAIN MEDICAL RECORDS

DATE: _____

PATIENT: First _____ Last _____

DATE OF BIRTH: _____

I hereby authorize Advanced Gynecology and Wellness, PA to (CHECK ONE)

RELEASE copies of my medical records to: OBTAIN copies of my medical records from:

Name/Business: _____

Address: _____

Phone: _____ Fax: _____

I understand that if the recipient authorized to receive the information as requested is not a covered entity, i.e. insurance company or non-healthcare provider, the released information may no longer be protected by federal and state privacy regulations.

ALL RECORDS

Mammogram reports
(indicate date range)

Pap Smear and Exam Notes
(indicate date range)

Laboratory results only
(indicate date range)

Other

By checking ALL RECORDS, I hereby give my express written consent to release all records regarding my full medical record without regard to content.

PLEASE SPECIFY description of purpose of the use/disclosure:

I understand this authorization will expire 180 days after the date of this authorization unless I otherwise specify. I also understand that I may revoke this authorization at any time upon written notice to Advanced Gynecology and Wellness, provided there is a valid signature and date. I understand any revocation to be effective upon receipt and does not apply to records released prior to the date of receipt.

Patient or Guardian

Date

Relationship to Patient