OBGYN ASSOCIATES

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

NAME: _____ Date of Birth: _____

I hereby authorize: _____
(Practice Name, Address, Phone, Fax)

_____

To release information from my medical record to:

_____
(Practice Name or Self, Address, Phone, Fax)

_____

At this time, I am requesting that the following information be released (check all that apply):

_____ My Complete Medical Records including but not limited to office notes, consultation and operative reports, medication history, phone call documentation, laboratory and imaging reports

_____ Complete Records of my medical care for the following specified dates of treatment:

From: _____ To: _____

_____ Records of my medical care for the following medical condition(s) only:

_____

_____ Other: please specify: _____

HIV/AIDS – I hereby give consent for the specific release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, along with the rest of my medical records.

SIGN: _____ **DATE:** _____

I understand by signing this request that Ob/Gyn Associates of Akron, Inc., is not responsible for lost, misplaced or stolen medical information/records once they are released.

I also understand by signing this request that Ob/Gyn Associates of Akron, Inc., in accordance to federal and state regulations, may charge a reasonable fee for copying your records and may also additionally charge for postage if you request that your records be mailed to you.

I understand that once I sign to have my records transferred from Ob/Gyn Associates of Akron, Inc., that my record is then sent to a secure storage unit. If for any reason Ob/Gyn Associates of Akron, Inc. must retrieve my medical record from storage, there will be a clerical fee for doing so.

I understand in accordance with federal law and HIPAA regulations that Ob/Gyn Associates, Inc., has thirty (30) days to process my request for medical records and release of information, and that at times with documentation of necessity, we can request an additional thirty day amendment to process the request if/when needed in certain circumstances.

I understand that this authorization for the release of medical information will expire within twelve (12) months of the original signature date unless otherwise indicated here: Expiration Date: _____ Initials: _____

Signature: _____ Today's Date: _____

Printed Name (first and last): _____