

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**  
**(PLEASE ALLOW 2-4 WEEKS FOR REQUEST TO BE PROCESSED)**

I \_\_\_\_\_ who resides at \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ hereby authorize:

Name: \_\_\_\_\_  
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY OR OTHER HEALTHCARE PROVIDER)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**To disclose/release my medical information to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Reason for request:** \_\_\_\_\_

Medical Information to be delivered by:  Mail  Fax # \_\_\_\_\_  Pick up

My authorization extends only to those data elements/documents **INITIALED** below:

_____ Statements of charges or payment	_____ Lab reports
_____ Records of visits (all visits)	_____ Hospital
_____ Record of visit for a specific date or dates (please specify) _____	
_____ Aids, HIV, Sexually Transmitted Diseases (STD)	
_____ Mental Health	_____ Substance Abuse
_____ All of the above	
_____ Other (must be specific) _____	

**This authorization is given freely with the understanding that:**

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. OB-GYN Associates of Montgomery, P.C., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

\_\_\_\_\_  
PATIENT'S NAME PRINTED

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

\_\_\_\_\_  
EXPIRATION DATE (IF OTHER THAN 1 YEAR FROM DATE ABOVE)

\_\_\_\_\_  
DATE OF BIRTH / \_\_\_\_\_  
LAST 4 DIGITS OF SOC SEC #

\_\_\_\_\_  
WITNESS

\*\*\*The most recent year of the patient record is copied as a courtesy, otherwise, the patient may be charged a fee for the copies set forth in the following schedule:  
\$10.00 for research and retrieval, \$1.00 per page for the first 25 pages and \$.50 per page for each additional page  
\*\*Records are copied in house; therefore you may receive a bill/invoice before records are released.