



Medical Records Release

Name: _____ Date of Birth: _____

I do hereby consent and authorize Madonna OB/GYN to:

- SEND my medical records TO: OBTAIN my medical records FROM:

Name of

Facility: _____

Address and Telephone/Fac #:

The purpose of this release is (check all that apply):

- Moving Insurance Purpose Second Opinion Transferring Care Personal Review
 Other: _____

Notice to Patient: You may cancel this authorization in writing at any time, except where the release of PHI has already occurred. This authorization will expire one year from the date of consent. New York Legislature has determined that a reasonable fee for copying medical records is \$0.75 per page or electronic records will be faxed at the cost of \$6.50. All records will be sent electronically unless otherwise requested as paper copies.

A description of the Protected Health Information (PHI) to be released: (please check one)

I consent to the release of all medical records including records, reports, or tests concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment. I also understand that the release of information related to the diagnosis or treatment of HIV requires an additional authorization. (This excludes any records transferred to Madonna OB/GYN from previous care providers).

I consent to the release of all medical records with the following exceptions: If you want to limit any records previously mentioned in any way, indicate exactly what you do not want release:

I consent to the release of all medical records pertaining only to the following treatment/condition:

I consent to the release of all medical records from _____(Date) to _____(Date)

Signature of Patient, Representative or Legal Guardian: _____

Date: _____

NOTICE TO RECIPIENT OF RECORDS: This information has been disclosed to you from confidential records that are protected by law. State law prohibits you from making any future disclosures of this information without specific written authorization of the person to whom it pertains, or as otherwise permitted by Federal or State Law.

Madonna OB/GYN 1815 South Clinton Avenue, Rochester, New York 14618

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