Michael Cotter, MD, David Stewart, MD, Ashley Walsh, MD
Cyndi Vista, ARNP CNM, Ronnie Jo Stringer, CNM

6400 W. Newberry Road, Suite 207, Gainesville, FL 32605
Phone: 352.371.2011 Fax: 352.384.3611

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

NAME:_____

ADDRESS:_____

PHONE:_____

BIRTHDATE:_____

SSN:_____

RELEASE RECORDS FROM:

OFFICE:_____

ADDRESS:_____

PHONE:_____

FAX:_____

RELEASE RECORDS TO: Gainesville OB/GYN

6400 W. Newberry Road, Medical Arts Building, Suite 207, Gainesville, FL 32605

PLEASE RELEASE THE FOLLOWING RECORDS:

____ OPERATIVE REPORTS ____ PRENATAL RECORDS ____ LAB REPORTS

____ PROGRESS REPORTS ____ RADIOLOGY REPORTS ____ ALL RECORDS

____ OTHER(Please specify)_____

____ I **ALLOW** INFORMATION TO BE TRANSMITTED BY FAX. I UNDERSTAND THAT THIS MAY LIMIT THE SECURITY OR CONFIDENTIALITY OF THE RECORDS.

____ I **DO NOT ALLOW** INFORMATION TO BE TRANSMITTED BY FAX.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION.

_____ _____

(PATIENT SIGNATURE) (DATE OF AUTHORIZATION)

I HEREBY AUTHORIZE COPIES OF MY MEDICAL RECORDS TO BE RELEASED FROM GAINESVILLE OB/GYN. I UNDERSTAND THAT THIS MAY INCLUDE INFORMATION REGARDING MEDICAL, SURGICAL, PSYCHIATRIC TREATMENT, DRUG TREATMENT, HIV TESTING, TESTING AND/OR COUNSELING. I RELEASE GAINESVILLE OB/GYN AND ALL STAFF FROM ANY AND ALL COSTS, LIABILITY OR DAMAGES RESULTING DIRECTLY OR INDIRECTLY.