Michael Cotter, MD
Heather Stevens, MD
David Stewart, MD
Cyndi Vista, ARNP CNM
Ronnie Jo Stringer, CNM

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT:

NAME:_____

ADDRESS:_____

PHONE:_____

BIRTHDATE:_____

SSN:_____

RELEASE RECORDS FROM:

OFFICE:_____

ADDRESS:_____

PHONE:_____

FAX:_____

RELEASE RECORDS TO: Gainesville OB/GYN

ADDRESS:_____ PHONE:_____ FAX:_____

PLEASE RELEASE THE FOLLOWING RECORDS:

__OPERATIVE REPORTS __PRENATAL RECORDS

__LAB REPORTS __RADIOLOGY REPORTS

__PROGRESS REPORTS __ALL RECORDS

__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.