MEDICAL RECORDS RELEASE

OBGYN
Obstetrics & Gynecology
Associates, Inc.

Today's Date _____

I hereby authorize Obstetrics & Gynecology Associates, Inc. to:

RELEASE MY ENTIRE MEDICAL RECORD TO:

Physician, Facility, or Self: _____

Address: _____

City_____ State _____Zip code _____

Reason for Release:

____ Specialist Appointment (Please specify date) _____

____ Leaving Practice (Please specify reason) _____

____ Other (Please specify reason) _____

____ At the request of the individual

-OR-

OBTAIN FROM: Physician or Facility: _____

Address: _____

City _____State _____Zip code _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV, Aids virus, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released:

- € **HIV/AIDS**
- € **Sexually transmitted diseases**
- € **Mental illness or mental health treatment**
- € **Drug and alcohol abuse treatment**

Patient's Name (print) _____Birthdate _____

Patient's Signature _____ SS#_____

Please note: There is a retrieval fee of $18.61 for any records having to be obtained from our off-site storage facility. Payment of this retrieval fee will be due prior to the retrieval of your records. There will also be a charge for a subsequent copy of medical records. We suggest you make a copy of your records prior to releasing them to another physician.

Please allow 14 to 21 business days to receive your records.

3050 Mack Road, Suite 375 Fairfield, OH 45014 phone (513) 221-3800 fax (513) 682-4520