FELLOWS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
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Medical Records Release Form

Patient Name:_____ DOB:_____

Phone Number: _____ Account number:_____

Requesting From	***Forward To***
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

Specific Documentation requested:

- ☐ Laboratory results
- ☐ Complete medical records
- ☐ Other (Please specify below)

_____

_____

_____

Patient Name:_____ Date:_____

Signature:_____

***Please be advised that whenever possible your medical records are given in a USB accompanied by a $10 charge. Records will sometimes need to be given in paper format, first 25 pages are $1 per page, .25 cents per page remaining.**

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