Maternal Fetal Specialists

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REQUEST FOR MEDICAL RECORDS

Patient's Name: _____ Date of Birth: ___

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number(s): _____

Name, address, telephone and fax number of physician:

A. Where your records are being requested from **OR**
B. Where you are requesting your records to be sent to **CIRCLE A OR B**

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

_____ The patient is hereby requesting any and all information related to past and present medical conditions, histories, diagnoses and treatment.

_____ The patient is requesting medical records concerning the period from _____ to _____.

_____

Please initial each item below to indicate your understanding.

_____ I understand that the medical records to be released may contain information related to HIV, AIDS, sexually transmitted diseases, alcohol/drug use or mental health services and I hereby authorize the release of this information.

_____ I understand that once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

Patient's Signature (or Authorized Person*): _____ Date: _____
*Relationship to Patient: _____ Parent _____ Legal Guardian _____ Other

Witness Signature: _____ Date: _____

This request if valid for a period of 90 days from the request.

Please promptly release these records for the benefit of the patient's continued care. If you are unable to