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### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

I hereby authorize (physician's name) \_\_\_\_\_

To disclose records obtained in the course of my evaluation and/or treatment to:

\_\_\_\_\_  
\_\_\_\_\_

I understand that I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for Premier OB/GYN Associates, PLLC to inform the requester that portions of the record have been withheld.

This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

Premier OB/GYN Associates, PLLC reserves the right to charge a \$1 per page fee for copying of medical records up to 16 pages and \$.25/page thereafter. If a fee is to be assessed, the patient will be informed of the total cost before medical records copies are made.

\_\_\_\_\_  
Signature of Patient or Substitute Decision Maker

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Substitute Decision Maker, state relationship

\_\_\_\_\_  
If Substitute Decision Maker, state reason

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

I DO consent to have this information disclosed  I DO NOT consent to this information being disclosed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This medical information may contain information concerning HIV testing and/or AIDS diagnosis. Separate consent must be given before this information can be disclosed.

I DO consent to have this information disclosed  I DO NOT consent to this information being disclosed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**REASON FOR REQUEST:**

MOVING OUT OF STATE  NO INSURANCE  APPLYING FOR MEDICAID

NEW PREMIER PATIENT REQUESTING RECORDS FROM PREVIOUS PHYSICIAN  
 TRANSFERRING CARE TO: \_\_\_\_\_

REASON: \_\_\_\_\_