Williamsburg Obstetrics & Gynecology

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Authorization for Release of Medical Records

Patient's name:_____ Date of Birth:_____

Address:_____

City/State/Zip Code:_____

Patient's Phone Number:_____

Date of Request/Needed by:_____

I authorize Williamsburg OBGYN to release/obtain information to/from:

Name of Provider/Facility:_____

Address:_____

City/State/Zip Code:_____

Phone Number/Fax Number:_____

PURPOSE FOR THIS REQUEST: (CIRCLE ONE) HEALTHCARE TRANSFER OF CARE PERSONAL

TYPE OF RECORDS REQUESTED: (CIRCLE ONE) SPECIFIC:_____

IMMUNIZATION HISTORY **COPY OF ENTIRE MEDICAL RECORD**

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a WRITTEN request to the address provided at the top of this form, except where a disclosure has already been made in rellance on my prior authorization.
- If the person or facility recieving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information; mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records

Patients/Representative's
Signature_____
Date:_____