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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____

Phone: _____

I hereby request that my medical records be released: **To** (or) **From**
 (check appropriate box)

- | | | |
|--|---|---|
| <input type="checkbox"/> M.O. Bayram, MD | <input type="checkbox"/> Danny Benjamin, MD | <input type="checkbox"/> David Cantor, MD |
| <input type="checkbox"/> Cathy Clubb, MD | <input type="checkbox"/> Vicki Kean, DO | <input type="checkbox"/> Yuliya Malayev, DO |

To (or) **From** Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Metro Obstetrics and Gynecology is authorized to release my health care information relating to the following treatment, conditions, or dates of treatment that they provided: (i.e. all records, recent tests, results [specify], etc.)

Please list reason for transfer: (i.e. moving, insurance change, transfer of care, etc.)

I understand health records in my file obtained from other health care entities may not be included in this request. I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug/alcohol use, you are specifically authorized to release all health information related to such diagnosis, testing, or treatment.

 Signature of Patient or Authorized Representative

 Date Signed

 Relationship to Patient, if not Patient