



PATIENT MEDICAL RECORDS RELEASE FORM

Form with fields: Patient Name, Date of Birth, Address, City, State, Zip Code, Social Security Number, Maiden Name, Other Names Used, Phone.

I HEREBY authorize medical information regarding the above identified person to be released

Table with 2 columns: From, Send To. From: OB/GYN Associates, P.A., 3520 E. Louise Drive, Meridian, Idaho 83642.

Reason for Request: _____

Approximate Date of Care From: _____ To: _____

Records Requested: _____

I understand that, unless otherwise specified by me, the records to be released by OB/GYN Associates, P.A. will include records created by OB/GYN Associates, P.A. as well as medical records created by other health care providers whose records are a part of OB/GYN Associates, P.A.'s chart.

PATIENT MUST INITIAL EACH BOX TO BE VALID AND PROVIDE PHOTO ID

- Alcohol, HIV Tests, Drug Abuse Records, Psychiatric/Mental Health Records, AIDS Diagnosis, Other: _____

We require a records fee (\$15.00 - \$75.00) be paid prior to pick-up/delivery by completing the attached payment authorization form. Please indicate if you prefer a paper copy or CD (PDF password protected file) and provide a copy of your driver's license or valid picture ID when requesting via fax or mail.

Please check here for: [] PAPER COPY [] CD/ELECTRONIC

I hereby consent to the release of the above information obtained in the course of my diagnosis and treatment. This authorization is valid for six (6) months from date of signature unless previously revoked in writing. Any re-disclosure of information obtained by this authorization is prohibited.

Print Name: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Provider Approval Signature/Date: _____