



Obstetrics & Gynecology Associates, INC.

Medical Records Release

3050 Mack Rd. Ste 375
Fairfield, OH 45014

Phone #: (513)221-3800 Fax #: (513)682-4520
Email: med_rec@cincyobgyn.com

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ City: _____ State: _____ ZIP: _____

I hereby authorize Obstetrics & Gynecology Associates, INC. to:

Obtain my Medical Records from:

Release my Medical Records To:

(Physician Name or Health Care Facility)

(Street Address)

(City, State, Zip Code)

(Phone #) (Fax#)

(Physician Name or Health Care Facility)

(Street Address)

(City, State, Zip Code)

(Phone#) (Fax#)

The information you may release or obtain subject to this signed release form is as follows:

- Complete Records
- Pathology Reports
- Hospital Records
 - From where? _____
- Lab Reports
- Progress Notes
- OP Notes
- Radiology Reports
 - Mammo Reports _____
 - Dexa Reports _____
 - USD Reports _____
- Other
 - Please Specify _____
 - _____
 - _____
 - _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV, AIDS virus, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released or obtained.

- HIV/AIDS
- Sexually Transmitted Diseases
- Mental Illness or Mental Health Treatment
- Drug and Alcohol Treatment

Patient's Name (Print) _____ Birthdate: _____

Patient's Signature: _____

Please note: There is a retrieval fee of \$19.58 for any records having to be obtained from our off-site storage facility. Payment of this retrieval fee will be due prior to the retrieval of your records. There will also be a charge for a subsequent copy of medical records. We suggest you make a copy of your records prior to releasing them to another physician.

Please allow 3 business days for electronic transmission and up to 14-21 business days to receive your paper chart records.