MEDICAL RECORDS RELEASE

Today's Date __________________________

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

<u>RELEASE MY ENTIRE MEDICAL RECORD TO</u>:

Physician, Facility, or Self: ____

Address: ____

City____ State ________Zip code ___________________

Reason for Release:

____ Specialist Appointment (Please specify date) ____________________

____ Leaving Practice (Please specify reason) _______________________

____ Other (Please specify reason) _______________________________

____ At the request of the individual

-OR-

<u>OBTAIN FROM</u>: Physician or Facility: ____

Address: ____

City __________________State ________Zip code __________________

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:

- ☐ **HIV/AIDS**
- ☐ **Sexually transmitted diseases**
- ☐ **Mental illness or mental health treatment**
- ☐ **Drug and alcohol abuse treatment**

Patient's Name (print) ____Birthdate ________________

Patient's Signature ____ SS#________________________________

<u>Please note</u>: There will 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 7-10 business days to receive your records.

3050 Mack Road, Suite 375 Fairfield, OH 45014 phone (513) 221-3800 fax (513) 682-4520