REQUEST & AUTHORIZATION TO RELEASE MEDICAL RECORDS

Westside OB-GYN Center
and Westside Women's Center

Patient Name: _____ **Medical Record Number:** _____

Date of Birth: _____ **Social Security Number:** _____

I authorize and request _____ to release medical
(Name of Person/Physician/Organization)

Information on the patient listed above to: WESTSIDE OB/GYN CENTER, PA to be mailed to:
(Person/Physician/Entity TO RECEIVE records-please be specific)

1091 Kirkpatrick Road
(Address)
Burlington, NC 27215

The specific information for the following dates of service: _____

INFORMATION TO BE DISCLOSED *(check the appropriate boxes and include other information where indicated):*

☐Summary Health Information: *(Includes Discharge Summary, History and Physical, Radiology, Pathology, Laboratory, and Dictated notes)*

☐History & Physical (e.g. doctor visit)

☐Discharge Summary

☐Operative Report

☐Immunization Records

☐Comprehensive Record

☐Radiology Reports

☐Laboratory Reports

☐Emergency Department Reports _____

☐Physical Therapy / Occupational Therapy Notes

☐Patient Discharge Plan

☐Other _____

☐Information contained in the patient's record related to psychiatric/psychological diagnosis, status, symptoms, prognosis, and treatment to date.

☐Information contained in the patient's medical record related to treatment for alcohol and/or drug abuse.

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:

☐Sharing with other health care providers as needed
☐Insurance processing
☐Legal reasons
☐Personal use
☐Other: _____

This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the Medical Records Management Department. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I understand authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____ _____
Date Signature of Patient or Legal Representative

If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-Patient's behalf. By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you am not prohibited by Court Order from having access to the requested medical records.