



## **Authorization to Release Medical Records**

I hereby authorize Modern Gynecology, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Medical record #: \_\_\_\_\_

Date(s) of treatment: \_\_\_\_\_

Release information to: (Name of individual or organization) \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

### INFORMATION TO BE RELEASED OR ACCESSED:

Office Clinical Notes     Procedure Notes     Lab/ Path Reports

X-Ray/MRI/CT Reports     Billing     Other: \_\_\_\_\_

Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)\*

\*requires special consent

### INFORMATION IS NEEDED FOR:

Continuing medical treatment     Litigation for review     Personal use

Insurance (company name): \_\_\_\_\_

Other (specify reason): \_\_\_\_\_



*I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.*

*I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.*

*The Authorization will expire six(6) months from the date of my signature, unless I revoke the authorization prior to that time.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient or Legal Authorized Representative

\_\_\_\_\_  
Printed Name of Patient or Legal Authorized Representative

\_\_\_\_\_  
Relation to Patient

A request may take several working days to process. If there are questions, please contact Modern Gynecology at 907-339-0363.

**Please Note :** A copying fee of \$25.00 may be charged “for furnishing a second copy of the patient's medical record upon request by the patient”.