ADVANCED OB/GYN

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MEDICAL RECORDS RELEASE

TODAY'S DATE _____

PATIENT'S NAME _____

DATE OF BIRTH _____ **SSN** _____

DATE NEEDED BY _____

I HEARBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM:
(MY PREVIOUS HEALTHCARE PROVIDER)

_____

_____

TO THE OFFICE OF:

ADVANCED OB/GYN

- ☐ **ALL RECORDS (PAST 3 YEARS ONLY)**
- ☐ **LAB RESULTS ONLY**
- ☐ **RADIOLOGY / X – RAY RESULTS ONLY**
- ☐ **HOSPITAL / SURGERY REPORTS ONLY**
- ☐ **OTHER RECORDS** _____

AUTHORIZING SIGNATURE **DATE**

_____ _____