WINCHESTER OB-GYN ASSOCIATES, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Home#: _____ Cell#: _____

☐ **I authorize Winchester OB/Gyn to RELEASE information to:**

_____
Name of Provider / Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # Fax #

OR

☐ **I authorize Winchester OB/Gyn to OBTAIN information from:**

_____
Name of Provider / Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # Fax #

PLEASE NOTE: *Normal processing time to produce medical records is 5-7 days. As a courtesy, we will copy and mail records to another physician or medical center free of charge. A fee of .25 cents per page will be charged for all other purposes.*

PURPOSE FOR THIS REQUEST: _____

TYPE OF RECORDS REQUESTED: (check one)

☐ All medical records; or

☐ I only want parts of my medical record, described below, to be disclosed:

_____

_____

AUTHORIZATION FOR RELEASE OF SENSITIVE OR STATUTORILY PROTECTED INFORMATION FROM THE MEDICAL RECORD

The following categories of information will NOT be released from your record unless you indicate your authorization by signing next to the corresponding category or categories:

☐ Alcohol Abuse	☐ Sexual Abuse	☐ Rape
☐ STD Testing	☐ Substance Abuse	☐ Sexual Assault
☐ Genetic Testing	☐ HIV Testing	☐ Mental Health

_____ _____

Signature of Patient (or Legal Representative) **Date**