Laurel OB/GYN
41 Oakland Rd, Suite 200
Asheville, NC 28801
P) 828-253-5381
F) 828-253-9087

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRINT PATIENT'S FULL NAME _____ DATE OF BIRTH _____

STREET ADDRESS _____ CITY _____

STATE, ZIP _____ PHONE NUMBER _____

I request my medical records to be released FROM: LAUREL OB GYN
Name of Company/Agency/Facility/Person
41 OAKLAND RD, STE 200
Street Address
ASHEVILLE, NC 28801
City, State, Zip
828-253-9087
Fax Number

____HISTORY AND PHYSICAL ____ LAB RESULTS ____BONE DENSITY
____PROGRESS NOTES ____ RADIOLOGY REPORTS ____ ER NOTES
____OTHER_____

_____

Release information TO:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

_____
Fax Number

PURPOSE OF DISCLOSURE:

____ REFERRAL TO SPECIALIST ____ INSURANCE ____WORKERS COMP ____ OTHER
____LEGAL INVESTIGATION ____ PERSONAL ____ DISABILITY DETERMINATION
____CHANGE OF DOCTOR

In order to better assist you and our other patients please list the reason(s) you are leaving our practice:

_____

I hereby authorize disclosure of the health information for the above patient. I authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving I, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individuals or Guardian or Personal Representative of Patient's Estate **Date**

Federal and State laws permit a fee to be charged for the copying of patient's records. This fee is based on a per page amount. Laurel OB-GYN will contact you and let you know how much your fee is before we send them out

****Office Use Only**** *AMOUNT CHARGED $_____ * PAID (CA, CHK#_____, CC) * INITIALS_____*

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