BROOKSIDE
gynecology

AUTHORIZATION
RELEASE OF MEDICAL RECORDS

Patient Name_______________________________Date of Birth___________________

Address____

Telephone #______________________Cell# ___________________________________

I hereby authorize Brookside Gynecology to: RELEASE OBTAIN DISCUSS
(Please circle information)

Medical Information (which may include all of specific info): TO FROM
(Please circle information)

Provider
Name____

Address____

Telephone #________________________Fax# _________________________________

Reason for request: _____Personal Use _____2nd Opinion _____Change in MD
_____Moving/other

RECORDS TO BE SENT: ____Entire Medical File/Office Notes/labs/radiology

____Other/please specify ____

Under state and/or Federal Guidelines, certain diagnosis and treatment may **NOT** be released without specific authorization. **Please initial if you WANT the information sent:**

Information of: Drug/alcohol abuse______ Psychiatric treatment______ HIV/AIDS_______

I have read and understand this authorization. I consent to disclose the above information to the person/agencies listed above. I release Brookside from all legal responsibility that may arise from the release of these records.

Patient Signature__________________________________Date____________________
(parent/legal guardian if patient is a minor)

Fees: **There is a fee of .45 per page, plus the cost of mailing/faxing before your records are released.**

Office Use Only: Sent_________________________By__________________________