



BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY  
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### AUTHORIZATION FOR REQUEST/RELEASE OF MEDICAL RECORDS

**Patient Information:**

Name: (Please Print) \_\_\_\_\_  
Last First Middle Initial Maiden (if applicable)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**I hereby request and authorize the release of my Medical records:**

**From:** Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_

**To:** Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Records to be released: (Please Specify)**

All: \_\_\_\_\_  
Or  
\_\_\_\_\_

**Reason For Request:**

Transfer of Care \_\_\_\_\_  
Second Opinion \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Other \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian Date

\_\_\_\_\_  
Signature of Witness Date