The Urogynecology Center, LLC
Patient Record Release/Request Form

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I hereby authorize:_____
(Person or facility)

To disclose my health information to:_____
(Person or facility)

Information to be disclosed including dates: _____

Information listed below will NOT be routinely disclosed unless initialed for authorization:

_____ Alcohol/Drug Abuse Treatment records
_____ Abortion information
_____ AIDS
_____ Mental Health
_____ STD's
_____ HIV

(If ALL information were to be disclosed, if could include the following: Notes by physician, physical therapy, dietary, etc,; phone messages, test and imaging results: medical history; referrals, correspondence and copies of complete health forms.)

I understand that once the uses/disclosures have been made as permitted by this form, the records/information may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by delivering in writing a revocation to The Urogynecology Center, but if I do, it will not have any effect on actions The Urogynecology Center took in reliance on this authorization prior to receiving the revocation. I authorize the use/disclosure of the records/information described above.

_____ _____ _____
Name: Print (Parent or Legal Guardian if Minor Child) D.O.B. Date

_____
Name: Signature (Parent or Legal Guardian if Minor Child)

Expires (not to exceed 1 yr): _____

****** **PREPAYMENT OF CHARGES FOR DUPLICATION OF RECORDS IS REQUIRED** ******

Please allow 10-15 days processing.

No charges if records are sent to a healthcare provider.

Charges $_____ **Date released** _____/_____/_____ **Reviewed by:** _____