Maternal Fetal Specialists
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MEDICAL RECORDS REQUEST

Patient's Name:_____ **Date of Birth:**_____
Address:_____ **State:**_____ **Zip code:**_____
Phone Number:_____ **Alternate Number:**_____
Name, address, telephone number and fax number of Provider or person to be released to

Records to be released from:_____
Phone Number:_____ **Fax Number:**_____

Records to be released to:_____
Address:_____
City:_____ **State:**_____ **Zip Code:**_____
Phone Number:_____ **Fax Number:**_____

_____ Patient Requesting all medical records
_____ Patient Requestions from_____ to _____

Please Initial each item below to indicate your understanding.

_____ I understand that the medical records to be released may contain information related to HIV, AIDS sexually transmitted diseases, alcohol/drug use or mental health services and I hereby authorize the release of this information.

_____ I understand that once that information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release if this information is voluntary. I don't need to sign this form to ensure health care treatment.

Patient's Signature (or Authorized Person):_____ Date:_____

*Relationship to Patient _____Parent _____ Legal Guardian _____ Other -Specify:_____

Witness signature:_____ Date:_____

This Request is valid for a period of 90 days from the request date.

Please promptly release these records for the benefit of the patient's continued care.