AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. REGARDING PATIENT

NAME – LAST, FIRST, MI		
STREET ADDRESS		
CITY	**STATE**	**ZIP CODE**
SSN	**DOB**	

2. RECORDS RELEASED FROM

NAME		
STREET ADDRESS		
CITY	**STATE**	**ZIP CODE**
PHONE #	**FAX #**	

3. RECORDS RELEASED TO

NAME		
STREET ADDRESS		
CITY	**STATE**	**ZIP CODE**
PHONE #	**FAX #**	

4. INFORMATION TO BE RELEASED

☐ Complete Copy of All Records ☐ Lab Reports ☐ Pap Smear History

☐ Counseling & Consultation Visits ☐ Records Pertaining to Pregnancy

☐ Other (Specify) _____

FOR THE FOLLOWING DATES _____

5. PURPOSE OF NEED FOR DISCLOSURES (check all that apply)

☐ Transferring Care ☐ Further Medical Care ☐ Application for Insurance

☐ Legal Investigation ☐ Personal ☐ Disability ☐ Other _____

No copy fee will be charged if records are sent directly to another physician or health care facility. You must pay a copy fee if you are requesting your records for any other reason.

I authorize the release of my medical records in accordance with the specification listed above. A faxed or emailed copy of this consent shall be valid as an original.

Signature of Patient _____ Date _____
(If not signed by patient, state relationship or authority to do so)

THIS FORM MAY BE FAXED TO 702-914-6904 OR EMAILED scheduling.legacyobgyn@lvcoxmail.com