Metro
Obstetrics & Gynecology

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____

_____

Phone: _____

I hereby request that my medical records be released: ☐ **To** (or) ☐ **From**
(check appropriate box)

☐ M.O. Bayram, MD ☐ Danny Benjamin, MD ☐ Radwan Asaad, MD

☐ Cathy Clubb, MD ☐ Vicki Kean, DO ☐ Yuliya Malayev, DO

☐ **To** (or) ☐ **From** Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Metro Obstetrics and Gynecology is authorized to release my health care information relating to the following treatment, conditions, or dates of treatment that they provided: (i.e. all records, recent tests, results [specify], etc.)

_____

Please list reason for transfer: (i.e. moving, insurance change, transfer of care, etc.)

_____

I understand health records in my file obtained from other health care entities may not be included in this request. I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug/alcohol use, you are specifically authorized to release all health information related to such diagnosis, testing, or treatment.

_____ _____
Signature of Patient or Authorized Representative Date Signed

_____
Relationship to Patient, if not Patient

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