**REQUEST FOR MEDICAL RECORDS**

PHYISICAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRACTICE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize you to use or disclose the specific information described below only for the purpose and parties described.

**PLEASE FORWARD MY RECORDS TO:** **Pineview Gynecology**

1322 Pineview Drive

Morgantown, WV 26505

Phone 304-599-8790 / Fax 304-599-8795

**FOR PROVIDER:**

* Cynthia Walsh, MD,FACOG Amy Kitzmiller, MSN, WHNP-BC
* Deborah Boyer, MSN, FNP-BC Brooke E. Rhodes, MSN, FNP-BC

**RECORDS ARE BEING REQUESTED FOR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DESCRIPTION OF SPECIFIC INFORMATION TO BE USED OR DISCLOSED:**

Office Notes (may include Psychotherapy notes) Pap Smears X-Rays

History & Physical Labs Mammograms

Hospital Summary Pathology Other

Operation Reports Ultrasounds

**FORMAT OF RECORDS RELEASE:** Fax Disk  Paper Copy

**DELIVERY METHOD:** Mail Pick-Up by Patient

This authorization shall remain in effect from the date signed below for **1 YEAR** (expiration date or event).

I acknowledge that the healthcare facility listed above, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to Pineview Gynecology. I have reviewed the NOPP of the healthcare facility and have been given the opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated authorization shall be as effective as the original. I release, hold harmless, and agree to indemnify the healthcare facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize the healthcare facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

HIV records (Including HIV test results) and sexually transmissible diseases Initial: \_\_\_\_\_\_\_

Alcohol and substance abuse diagnosis and treatment records Initial: \_\_\_\_\_\_\_

Psychotherapy records/this serves as my signature release under Federal law Initial: \_\_\_\_\_\_\_

Other/Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_

I may inspect a copy of my protected health information to be used or disclosed under this consent. I have the right to revoke this authorization in writing by contacting the healthcare facility, attention Privacy Officer. The healthcare facility has not conditioned provision of services to or treatment of my upon receipt of this signed authorization; and that I may refuse to sign this authorization.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Patient’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parental Signature (if patient is under 18 years old): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Representative (Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient/Authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**