**Authorization for Release Medical Records**
**To Upstate OBGYN**

Patient Name: _____
Address: _____

DOB: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

Phone Number: _____

**This is my written authorization for Upstate OB/GYN Group To Obtain Information From:**
Physician: _____
Address:_____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number:_____
Release Format: ☐ Mail ☐ Fax: 864-271-9785 ☐ Pick Up ☐ Other: _____

**Information to be Released:**

☐ All Medical Records ☐ Lab Reports ☐ Dr. Notes
☐ Prenatal Records ☐ x-ray/Ultrasound ☐ Hospital
☐ Demographics ☐ insurance ☐ Other: _____

**Purpose of Disclosure:**

☐ Changing Physicians ☐ Moving ☐ Referral
☐ Insurance Claim ☐ Legal ☐ Other: _____

**I understand that these records may include information on sexually transmitted disease, AIDS, HIV, mental, health, alcohol/drug abuse.**

☐ **YES, I authorize the release of this information.**
☐ **NO, I do not authorize the release of this information.**

REVOCATION: I understand this authorization may be revoked in writing at any time. Unless otherwise indicated, this authorization will expire 90 days from the date of signature. The physician and the employees are released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Medical records are released within five (5) to seven (7) business days from the date of receipt of this completed request form. Fee may apply to this request which may be the patient's responsibility.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian: _____
Date: _____