CHENA *Obstetrics & Gynecology*

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REQUEST FOR MEDICAL RECORDS

Please Print Information
I hereby authorize Chena Obstetrics & Gynecology to:

_______ Release Information To: _______ Obtain Information From:

Person/Agency: ____

Address: ____

City, State, Zip: ____

Phone: _________________________ Fax: ________________________________

Information Requested
The information covered by this authorization includes: **(Please check one)**

- ☐ Entire medical record ☐ Immunization/Injection information
- ☐ Pregnancy information only, dates: ____
- ☐ Information from: ____________________ To: ________________________________
- ☐ Operative Note: ____

Purpose of Information
Information listed above will be disclosed for the following purposes:
____

I understand that my medical record may include sensitive information including but not limited to the Diagnosis & treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), HIV status and/or STD's. I understand & agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES: (you must initial one)

I do _____ do not _____ authorize this information to be released

Expiration, Revocation, and Redisclosure of Authorization
This authorization will expire 1 year from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this signed authorization by notifying Chena Obstetrics & Gynecology in writing. When your medical information is released pursuant to a valid authorization you should be aware of the following: That the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

______________________________________ _____________________
Patient Name Date of Birth

______________________________________ _____________________
Signature of Patient/Legal Representative Date

____
Relationship to Patient