Medical Records Request/Release

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Phone Number: _____

☐ Request Records From: ☐ Release Records To:	☐ Request Records From: ☐ Release Records To:
OBGYN West 14001 Ridgedale Drive, Suite 200 Minnetonka, MN 55305 P: 952-249-2000 F: 952-249-2099	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ P: _____ F: _____

Please be as specific as possible.

Release the following medical records from _____ (date) to _____ (date). **Records may be limited to last 2 years.*

☐ Office Notes
☐ Lab Reports
☐ Operative/Procedure Notes & Pathology
☐ Ultrasound Reports
☐ Prenatal/Delivery Records
☐ Other:_____

The reason for release is: **Fee may apply*

☐ Continuation of Care
☐ Litigation*
☐ Transfer of Care
☐ Insurance Application*
☐ Out of Town Move
☐ Other: _____

This authorization will expire one year from the date of signature below **or on** _____ (date).

I understand that I have the right to revoke this authorization at any time by sending a written notice to OBGYN West. Revocation of this authorization will not apply to records that have already been released.

I understand that information released pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Records containing information related to Alcohol or Drug use, Mental Health, and/or HIV or AIDS will be released unless you indicate below.

- ☐ Do not release Alcohol or Drug use records.
- ☐ Do not release Mental Health records.
- ☐ Do not release HIV or AIDS records.

OBGYN West will not condition my treatment based on whether I sign this authorization.

Patient/Legal Guardian Signature *(state relationship to patient)* Date