

Premier Obstetrics and Gynecology of Orlando, P.A.

531 N. Maitland Avenue Maitland, Fl. 32751

Phone: 321-397-1212 Fax: 321-397-1213

MEDICAL RECORDS RELEASE FORM

Date: _____ Name: _____ Date of Birth: _____

Social Security# _____ Number # to reach patient: _____

Please Indicate Which One Applies To You:

_____ Obtain my records from my previous provider: (Complete the provider information below.)

_____ Please mail or fax my records to: (Complete the information below.)

_____ Allow me to pick up my records.

Please Note: If you are coming in to pick up your records, want them mailed or faxed to you, or to another office *without a referral* from our office, there is a charge of \$1.00 per page for the first 25 pages and 25 cents for every page after that. **Pre payment** is required by **check or cash only** before we can send out any records.

Please complete the following:(Physician, Self, Insurance, or Other)

Name: _____ Phone: _____

Address: _____ Fax: _____

Please Indicate Each That Applies:

_____ All Medical Records _____ Office Visit Notes _____ HIV Testing

_____ Surgical Reports _____ Lab Results _____ X-Rays/Ultrasounds/Radiology Reports

(If This Applies)Please Advise Us If You Are:

_____ Transferring out of our office permantly or _____ Just seeing a 2nd Physician

I UNDERSTAND THIS CONSENT IS REVOCABLE BY ME, IN WRITING, AT ANY TIME EXCEPT AFTER THE ACTION HAS TAKEN PLACE. I ALSO UNDERSTAND THAT THIS CONSENT WILL EXPIRE IN THIRTY (30) DAYS AFTER THE DATE OF SIGNATURE OR AUTOMATICALLY WHEN THE RECORDS REQUESTED ON THIS FORM HAVE BEEN MAILED, FAXED, OR PICKED UP TO THE ABOVE REQUESTED FACILITY. *PROHIBITION ON RE DISCLOSURE:* THIS INFORMATION DISCLOSED TO YOU FROM RECORDS FOR WHICH CONFIDENTIALITY IS PROTECTED BY LAW. ANY FURTHER RE DISCLOSURE IS STRICTLY PROHIBITED.

*****ALL REQUESTS DONE WITHIN 72 HOURS*****

Signature: _____

Date: _____