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
❒ Deborah Boyer, MSN, FNP-BC
❒ Amy Kitzmiller, MSN, WHNP-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)
❒ History & Physical
❒ Hospital Summary
❒ Operation Reports
❒ Pap Smears
❒ Labs
❒ Pathology
❒ Ultrasounds
❒ X-Rays
❒ Mammograms
❒ Other

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: _____