Contemporary Obstetrics and Gynecology, P.C.

Board Certified
Obstetrics and Gynecology
www.ContemporaryDoctors.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Richard S. Duff, M.D., F.A.C.O.G.

Brian K. Reedy, M.D., F.A.C.O.G.

Andrea C. Blake, M.D., F.A.C.O.G.

Daniel J. Greene, M.D., F.A.C.O.G.

Dawn M. Goulding, M.D., F.A.C.O.G.

Sapna Murthy, M.D. F.A.C.O.G.

Kelly Gumbrecht, M.D. F.A.C.O.G.

Gouri Pimputkar, D.O. F.A.C.O.O.G.

Patient Name: _____ DOB: _____

Last 4 of Social Security #:_____ Phone Number: _____

I hereby request that my medical records be released: ☐To (or) ☐From
(Check appropriate boxes)

☐Richard S. Duff, MD ☐Brian K. Reedy, MD ☐Andrea C. Blake, MD

☐Daniel J. Greene, MD ☐Dawn M. Goulding, MD ☐Sapna Murthy, MD

☐Kelly Gumbrecht, MD ☐Gouri Pimputkar, MD

☐To (or) ☐From: Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Contemporary Obstetrics & Gynecology, PC, is authorized to release my health care information relating to the following treatment, conditions or dates of treatment that they provided: (ie., all records, recent tests results (specify), etc.)

_____

Please list reason for transfer: (ie., moving, insurance, transfer of care, etc.)

_____

Fee for Medical Records: Initial fee: $23.32 / First 20 pages: $1.16 each / Pages 21-50: .58 each / Pages 51-Over: .23 each / Postage Fee: to be determined
(Once fee is calculated, you will be contacted for pre-payment.)

I understand health records in my file obtained from other healthcare entities may not be included in this request. I understand that my express consent is required to release any healthcare information related to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health information related to such diagnosis, testing or treatment.

THIS AUTHORIZATION EXPIRES 90 DAYS FROM DATE SIGNED

_____ _____
Signature of Patient or Authorized Representative Date Signed

_____
Relationship to Patient, if not Patient

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