Medical Records Release

Patient Name: ________________________ Date of Birth: ________________

Previous Name: ________________________ Phone Number: ________________

I authorize OBGYN West to release medical records/health information pertaining to:

☐ Pregnancy/Delivery ☐ Surgery

Physician: ________________________ Due Date (if applicable): ________________

This information will be released to my Employer/Disability Insurance Company for the purposes of FMLA/Short Term Disability only.

Obstetrical Patients: I will be required to sign this consent at my 28-week OB visit. OBGYN West cannot release information to my employer or disability insurance company without my written consent. This authorization will expire at the end of my current pregnancy.

Surgery Patients: This authorization will expire two months after the completion of my surgery.

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.

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

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