



# Medical Records Request/Release

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

<input type="checkbox"/> Please Release My Records From: <input type="checkbox"/> Please Release My Records To:  OBGYN West 14001 Ridgedale Drive, Suite 200 Minnetonka, MN 55305 P: 952-249-2000 F: 952-249-2099	<input type="checkbox"/> Please Release My Records From: <input type="checkbox"/> Please Release My Records To:  Name: _____ Address: _____ City: _____ State: _____ Zip: _____ P: _____ F: _____
--	--

**Please be as specific as possible.**

Release the following medical records from \_\_\_\_\_ to \_\_\_\_\_.  
(date) (date)

*\*Please allow 30 days, if you are requesting records from greater than 3 years ago. Fees may apply.*

- |  |  |
|--|--|
| <input type="checkbox"/> Office Notes                          | <input type="checkbox"/> Ultrasound Reports        |
| <input type="checkbox"/> Lab Reports                           | <input type="checkbox"/> Prenatal/Delivery Records |
| <input type="checkbox"/> Operative/Procedure Notes & Pathology | <input type="checkbox"/> Other: _____              |

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Transfer of Care       | <input type="checkbox"/> Out of Town Move |
| <input type="checkbox"/> Litigation*          | <input type="checkbox"/> Insurance Application* | <input type="checkbox"/> Other: _____     |

**This authorization will expire one year from the date of signature below.**

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. Please allow 10 business days for processing.**

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

*This Medical Records Request/Release may be submitted to OBGYN West via the mailing address or fax number listed above or by e-mailing the form to [medicalrecords@obgynwest.net](mailto:medicalrecords@obgynwest.net). Please note that e-mails and files sent to this e-mail are not encrypted.*