Gros Ventre OB/Gyn, LLP

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Maiden Name and or Alias (IF applicable): _____

This authorizes that medical information regarding the above identified person be forwarded to:

Individual or Agency Requesting Records: _____

Mailing Address: _____

Phone: _____ **Fax**: _____

Concerning treatment from: _____

REASON: Continuation of Care _____ Insurance _____ Litigation _____ Personal/Other: _____

- There is a charge for copies of medical records. Please see the copy fees listed below.
- Usual turnaround time for a request to be completed is within 7 business days from the date of receipt. Additional time may be necessary to process your request if the requested information is located off site or if the authorization to use, disclose or release health information is not properly filled out.
- A photocopy of this authorization shall be considered as valid as the original.

Gros Ventre OB/Gyn, LLP - Medical Record Fee Schedule	
Patients	$50 per chart volume copied (includes necessary postage and shipping fees)
Attorney, Insurance & Record Services	$100 flat fee (no maximum # of pages, includes necessary postage and shipping fees)

Total Charge: $_____ **Date Paid: _____**

I hereby consent to the release of the above information. I release Gros Ventre Ob/Gyn, LLP and my attending physicians(s) from all liability and all claims of any nature whatsoever pertaining to disclosure of information concerning the above named patient.

No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for conditions pertaining to alcohol and/or drug abuse, mental disorders or sexually transmitted diseases; including Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid for twelve (12) months unless revoked earlier in writing.

Please Initial_____.

Signed: _____Date:_____

***IF** signed by other than patient:*
Relationship to Patient _____
Patient unable to sign due to: _____