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1506 N. McKenzie Street | Suite 104 | Foley, AL 36535
Office: 251-424-1100 | Fax: 251-424-1110
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Authorization for Release of Medical Records

Patient Name: _____ **DOB:** _____ **SSN:** _____

I authorize Baldwin GYN & Aesthetics to **REQUEST / RELEASE** a copy of my medical records.

Physician/ Health Care Facility: _____

Address: _____

Phone: _____ **Fax:** _____

For the purpose of: _____

The following individually identifiable health information may be released:

[ ] All Dates **[ ]** Specific Date(s): _____ **[ ]** Past 12 Months

[ ] All Records **[ ]** OB Records **[ ]** Demographics **[ ]** Operative Records **[ ]** Pap Records

[ ] Lab Reports (specify): _____ **[ ]** Radiology Reports (specify): _____

[ ] Other: _____

When my information is used or disclosed to pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Baldwin GYN & Aesthetics, P.C. has acted in reliance upon this authorization.

By signing this authorization, I understand I am giving permission to the above party to disclose Protected Health Information (PHI), which may include, but is not limited to, the release of medical, psychological, psychiatric, alcohol, drug abuse, and HIV/ AIDS information.

_____ _____
Printed Name of Patient or Legal Guardian **Signature of Patient or Legal Guardian**

_____ _____
Signature of Witness **Date**