COASTAL PERINATAL CENTER

V Sachar, MD, FACOG, CHCQM, Maternal Fetal Medicine

Release of Medical Information

Permission to get records

I, _____,with a date of birth,_____, give my
(patient name) (patient's DOB)

permission for_____to give my medical records to
(doctor's or hospital name who has records)

Coastal Perinatal Center, Dr. V Sachar so that he can better understand my condition and help me.

Permission to get sensitive information

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:
_____ my mental health,
_____transmittable disease I may have like HIV/AIDS,
_____genetic records, and/or
_____drug and alcohol records.

I understand that:

- I do not have to give my permission to share these records.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.
- This form is only good for 3 months from the date I sign it**.**

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date_____

Relationship of Authorized Representative_____

Consent for release of medical records for _____
(patient name)

Date: _____

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Release of Medical Information

Requesting records from:

Name of Practice:_____

Name of Physician:_____

Fax number:_____

Address:_____

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other _____

Records within the following dates:

☐ All records for this patient

☐ Records dated between _____and _____

Please send records to:

Attention:_____

At fax number:_____

Or mail to:_____

_____

_____

For any questions please call:424-250-9186

and ask for:Office Manager