Medical Records Release Authorization Chart # _____

GYN Center For Women, P.A.
Pouru Bhiwandi, M.D.
(919) 782-8882 (919) 782-8028 fax

Name _____ Birthdate ___/___/____

Date ___/___/___ Phone ( ) _____-_____

Address _____

City _____ State _____ Zip _____

I hereby authorize

Pouru Bhiwandi, M.D.

3100 Duraleigh Rd., Suite 307, Raleigh, NC 27612

To release my medical information

To: _____

_____

_____

(___)___-_____ fax(___)___-____

OR

I hereby authorize

the release of my medical information

To: Pouru Bhiwandi, M.D.

3100 Duraleigh Rd., Suite 307, Raleigh, NC 27612

From: _____

_____

_____

(___) ___-_____ fax (___) ___-_____

If you were referred to this doctor please tell us who referred you. _____

Purpose for Need of Disclosure, at the request of the individual. _____ (please check)

Are you terminating your relationship with this practice and transferring your care? (please circle one) **Yes No**

Information to be released: NOTE: Most doctors only want pertinent records (not years of normal results Whole charts will cost you more in copying fees.

_____Complete Medical Records (including all of the below, or check specific record need)

_____Medical History
_____X-ray and Radiology Reports
_____Laboratory Reports
_____Mental Health
_____Sexually Transmitted Disease Reports
_____Alcoholism
_____Developmental Disabilities
_____Other, Specifically _____

_____Surgical Reports
_____Hospital Records and Reports
_____Prescriptions
_____Consultations
_____Drug Abuse and Tobacco Use
_____Allergy Records
_____HIV Test Results

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive Copy of This Authorization.**
- **Refuse to Sign This Authorization,** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization,** except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will have an expiration date of: _____ or one year if not otherwise specified.

Dr. Bhiwandi will charge of $25.00 for copying records, more for large charts. We must receive payment before records car be copied, faxed, or mailed out. We accept cash, credit cards, and personal checks.

_____ _____

Signature of Patient (or Legal Representative) If signed by Legal Representative: Relationship to Patient (Authority to act on patient's behalf)

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