

# Spring Ob/Gyn, PC

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## RECORD RELEASE

This form must be filled out in its entirety before we can comply with record requests.

New York State law requires all patients requesting the release of their medical records to give permission in writing. Permission to release HIV related records to any person, company or institution must also be specifically requested in writing.

By completing this form, I authorize the release of my medical records, including any HIV test results, from Spring Ob/Gyn P.C.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Are you transferring your care out of our office?  Yes  No

If you only require specific reports or results, please specify which ones below:

Please release my records to:

Myself

Dr. \_\_\_\_\_

Other third party: \_\_\_\_\_

I would like my records to be:

Picked up in person at the office

Mailed to the following address: \_\_\_\_\_  
\_\_\_\_\_

Faxed to: (\_\_\_\_) \_\_\_\_\_  
Attn: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_