4151 HOLIDAY STREET, N.W. – CANTON, OHIO 44718 – TELEPHONE (330) 492-8001
FAX (330) 492-2080 – WWW.ATRIUMOBGYN.COM

Medical Records Consent Release

Name: ________________________________ Birthdate: ____________________________________

Address: ______________________________ SSN#:_______________________________________

______________________________ Primary Phone: __________________________________

Please release a copy of my medical records from ATRIUM OB/GYN INC to:

Name: ____

Address: ____

☐ Mail ☐ Fax to: __________________ ☐ Will Pick Up

Medical records may contain previous doctor records, hospital records and/or information regarding Sexually Transmitted Infections (STI's) including HIV/AIDS; alcohol and/or other drug use or physical abuse. For that reason, please be specific about the information you wish to have released.

_____Entire medical record including alcohol, drug, STI or abuse that may be contained in it.

From: ____-_____-_____ To: ____-_____-_____
(date) (date)

_____I do NOT wish to have my entire medical record released.

Release only the following: ____

From: ____-_____-_____ To: ____-_____-_____
(date) (date)

Purpose of request or need for information: Continuation of Care_____ Transfer of Care____ Personal_____ Other_____

NOTE: You may withdraw permission for the release at any time prior to the expiration date by providing written notice to Atrium OB/Gyn Inc. Information released by Atrium prior to a patient's withdrawal of consent cannot be retrieved, and Atrium OB/Gyn Inc. will not be held responsible for such.

I hereby request Atrium OB/Gyn Inc. to release my records as I have instructed above, and release Atrium OB/Gyn Inc. from all legal responsibility that may arise from this act. I understand that I will be responsible for any charges incurred for copying and/or sending my medical records as permitted by law. Authorization will expire sixty (60) days from date of signature.

Patient Signature: ____ Date: ____________________

Witness Signature: ____ Date: ____________________

☐ **Patient ID # ______________** ☐ **Known Person to Employee** ☐ **Signature on File (Medical Records Use Only)**

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Pick Up Verification:

☐ **Patient ID# _________________** ☐ **Known Person to Employee** **Employee Initials: __________**