South Shore/Hanover Obstetrics and Gynecology, Inc.

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Written Consent to Release Medical Forms

PLEASE NOTE Medical records cannot be produced upon demand. Processing time is 7-10 days.

Date: ______________________________ Account Number: ____________________

Name: ____

Address: ____
street city state zip

Date of Birth: __________________________ Telephone: ______________________

Specific Request

☐ Entire medical records
☐ Entire medical records EXCEPT: ________________________________
☐ Specific medical records pertaining to: ____________________________

Reason for Request

*Leaving the practice due to: (Please check appropriate category)

☐ Changed Insurance. Name of new company: __________________________
☐ Not satisfied. Reason: ____
☐ Other: ____

Release Records to the Following: Name: ________________________________

Address: ________________________________

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Unless otherwise stated, the fee for processing the release of medical records is as follows:

1-3 pages $5.00 4-10 pages $10.00 11-25 pages $25.00 10 per additional page

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I, ________________________ herby consent to the disclosure of my medical records. I also hereby release South Shore / Hanover OBGYN Physicians and personnel from any liability in connection with such disclosure.

This consent is subject to revocation at any time, except to the extent that action has been taken by South Shore / Hanover OBGYN Physicians and their personnel good faith.

____ ______________________
Signature of Patient (or parent/guardian if under 18) Date

____ ______________________
Signature of Witness Date

Office Use Only: **chart copied:** ____