Kimberly Priebe, MD
Christian Garcia, MD
Mareca Pallister, MD
Megan Palmer, MD
M. Brie Todd, MD
Jeunesse Fredrickson, MD
Jennifer Berarducci, DO
Rachel Morr, PA-C
Aimee Birgenheier, WHCNP-BC
Sara Whitehead, PA-C
Lauren Melancon, FNP

CONSENT TO RELEASE/OBTAIN MEDICAL RECORDS

DATE_____

PATIENT: FIRST NAME_____ LAST NAME_____

DATE OF BIRTH_____ SOCIAL SECURITY_____

I HEREBY AUTHORIZE FOUR CORNERS OBGYN TO: (CHECK ONE)

_____TO RELEASE COPIES OF MY MEDICAL RECORDS

_____TO OBTAIN COPIES OF MY MEDICAL RECORDS

TO/FROM:

NAME/BUSINESS_____

ADDRESS_____

PHONE_____FAX_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.
The following information is requested and may be released:

☐ALL RECORDS

☐ OB records only

(indicate date range)_____

☐Pap smear and exam notes

(indicate date range)_____

☐Lab results (indicate date range)

_____

☐OTHER_____

By checking ALL RECORDS, I hereby give my express consent to release all medical records regarding my treatment, including genetic information and testing, family history, psychological treatment, drug abuse, alcohol use, human immunodeficiency virus (HIV) infection including acquired immunodeficiency syndrome (AIDS) or test for HIV or sexually transmitted diseases.

*PLEASE SPECIFY description of the use and/or disclosure:

_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specigy. I further understand that I may revoke this authorization at any time for notifying Four Corners OBGYN in writing. I also understand the the written revocation must be signed and dated with a date later than the date on this authorization. The revocation will not affect any actions taken before receipt of the written revocation. I understand that copies of records may be subject to a $25.00 fee.

_____ _____/_____/_____

(Signature of Patient or Representative) Date

_____(Name and relationship to patient if other party is signing)