# Babies' Etc., OB/GYN P.C.

235 Portal Lane Suite A
Madison, AL 35758
Office: (256) 461-1766 Fax: (256) 461-1768

***Jacqueline Sylvester, MD***


## Authorization for Release of Medical Records from another Facility

Patient's Name: _____
Address: _____
_____
Home Phone: _____
Date of Birth: _____
Social Security: _____

Physician's Name: _____
Office contact Person: _____
Physician's Address: _____
_____
Physician's Phone: _____
Physician's Fax: _____

**PLEASE NOTE:** If you wish for your records to be faxed, you must initial here: _____ Please be advised that patient confidentiality **cannot** be guaranteed when faxing medial records. In the event the patient chooses not to initial the above; all medical records are requested to be mailed to:

**Babies' Etc., OB/GYN P.C.**
**235 Portal Lane Suite A**
**Madison, AL 35758**

The medical records information will be used for continued medical care and /or treatment and should include:

- ☐ All medical records, i.e.: Labs, Pap Smears, Delivery/Operative Reports between the period of _____ to _____.
- ☐ Hospital Admission(s) and Discharge Summary(s).
- ☐ Office Visit Notes Only.
- ☐ Last Office Visit Note Only & Lab Only.
- ☐ Other: _____

I acknowledge that the data to be released may include material that is protected by law. I also acknowledge that I have the right to revoke this authorization, in writing.
The written revocation must include:

- ☐ The patient's name, date of birth and address
- ☐ Initial date of authorization and the recipients of the protected health information according to this authorization.
- ☐ The patient's desire to revoke this authorization, the date of the authorization, and the patient's signature.

**NOTICE: 30 days after accepting your revocation rights, Babies' Etc. OB/GYN PC will not be held liable for any medical condition(s) and /or treatment(s).**
I acknowledge that, once this information is disclosed, it **may not** be re-disclosed to any other organization. My check mark, initials, and/or signature may be used as authorization for the release of the above records.

**NOTE: This authorization will expire 30 days from the date indicated above.**

_____ _____
(Patient's Signature and relationship) (Date)

_____ _____
(Staff Witness) (Date)