RUETZEL GYNECOLOGY & OBSTETRICS PC
824 Greenbrier Pkwy, Ste 100, Chesapeake, VA 23320
Phone: 757-410-7390 Fax: 757-410-7395

Authorization to Release Medical Records

Patient Name: _____**Date of Birth** _____
Patient Phone Number _____

This authorizes Name: RUETZEL GYNECOLOGY & OBSTETRICS

Address: 824 GREENBRIER PKWY, STE 100, CHESAPEAKE, VA 23320

Phone/Fax: PH: 757-410-7390 FAX: 757-410-7395

to provide a copy, summary, or narrative of my medical records as indicated by the checkmark(s) below, or otherwise release confidential information.

- ☐ Complete record
- ☐ Records of care from the following dates: _____ to _____
- ☐ Records concerning the following condition: _____
- ☐ Other, please specify: _____
- ☐ Confer with person(s) listed below orally about my medical information:

The reasons or purposes for this release of information are as follows:

_____

_____

HIV/AIDS (if applicable) I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Initial _____ Date _____

Release to the following person(s):

Name: _____

Street _____

City _____State _____ ZIP _____

Expiration Date _____ or Expiration Event as detailed below:

- I understand that this information will be provided within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Virginia Statutory Code.
- I understand that I may revoke this authorization in writing at any time by notifying RUETZEL GYNECOLOGY & OBSTETRICS PC in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.

PATIENT SIGNATURE _____ DATE: _____